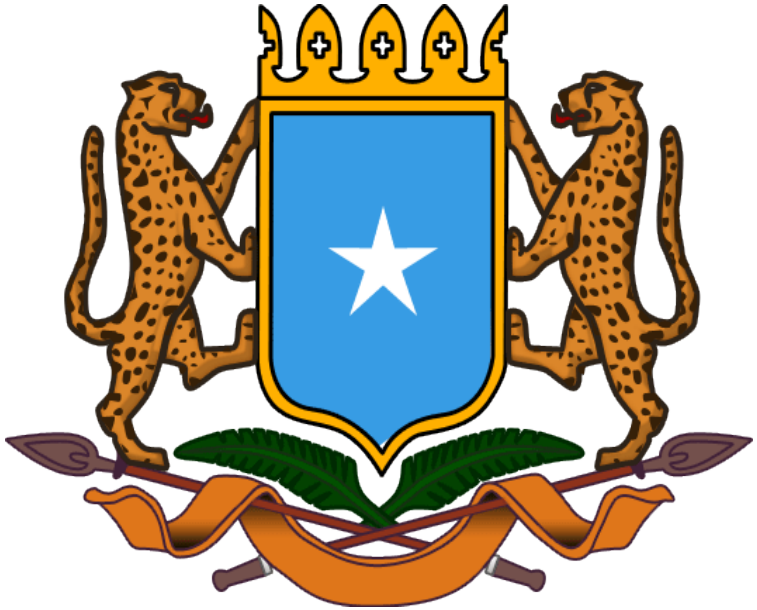
THE FEDERAL GOVERNMENT OF SOMALI REPUBLIC

MINISTRY OF HUMAN DEVELOPMENT AND PUBLIC SERVICES

DIRECTORATE OF HEALTH



Health Sector Strategic Plan
January 2013 – December 2016

"Our vision is to have a healthy and productive population contributing to the development of the nation".

Foreword Dr. Marian Qasim, Minister of Human Development and Public Services of the Federal Government of Somali Republic Directorate of Health

I am pleased to present the Health Sector Strategic Plan (2013 – 2016). This plan is presented in order to guide national and international investments in the health sector that will result in achieving our vision for the future - "a healthy and productive population contributing to the development of the nation".

Over the last two decades the health system has collapsed across many parts of the country and the combination of insecurity, drought and famine have caused huge population displacement and resulted in our population having some of the worst health indices in the world. The new political developments and improving security across the country now provides an opportunity for rebuilding our health system. The new Health Sector Strategic Plan (2013-2016) is fully owned by the Federal Government and sets out an ambitious agenda for rebuilding the health sector across South Central Somalia. This Plan provides the basis for renewed cooperation and alignment with our national and international health partners. The HSSP uses the WHO's six building blocks of an effective health system as a foundation for our plan and we are grateful for the cooperation from our international partners in its development.

We believe that this new HSSP is both practical and realistic in the context of Somalia and the rapidly evolving political and social situation. Our programme of work is based on a pragmatic assessment of our capacity, resources and the challenges that face us.

The plan has been developed through a process of broad consultation with the key stakeholders in the health system. We therefore anticipate that these stakeholders will be committed to the implementation of the Plan.

Finally, I would like to thank all partners for the excellent work in developing this plan and for the on-going work throughout the country.

I commend this Health Sector Strategic Plan to you, and count on your support to make it a success.

Dr. Marian Qasim
Minister of Human Development and Public Services

Acknowledgements

I am pleased to present the Somalia Health Sector Strategy (2013 to 2016).

I would like to thank the Health Strategic Plan Working Group, led by Dr. Abdi Awad Ibrahim, Resident Advisor for the Directorate of Health, for leading the development of this plan. The Working Group was assisted by consultants from MannionDaniels Ltd., supported by WHO Somalia.

A great many stakeholders contributed to this Strategic Plan. Ministry of Health staff in Mogadishu and our Regions, UN Agencies and NGOs who provide invaluable support to our health services, representatives from the private sector, and many others participated in the development of the Plan.

Also, I wish to acknowledge the support of the donors (UKAID, SIDA, AUSAID and USAID) and UN partners of the Joint Health and Nutrition Programme for funding the development of the Plan.

The Health Sector Strategic Plan is not intended to be a comprehensive and detailed review of the health sector in Somalia. Such reviews are already available, for example in the National Health Policy. Instead, it is written to be a concise, readable and practical plan with clear measurable objectives that will lead to *results*. The government will use the plan to:

- Build its capacity in governance and leadership to better manage the rebuilding of the health system and improve services to all the population.
- Develop annual work-plans and budgets at the Central, Regional and later District levels.

- Share with funding partners to secure the financial resources needed to implement the Plan and coordinate these to support the strategies in the Plan, thus reducing the transition costs associated with development support and helping to make it more effective.

- Communicate to the UN, NGOs and other partners that can contribute to the implementation of the Plan.

Most strategic plans fail because they have been developed simply for having a plan for its own sake, because they do not understand the external environment, because they are too long, complicated, and detailed, and because they have unrealistic goals given level of resources – they try to solve everything. The Working Group has avoided these mistakes and I hope that therefore this plan stands a better chance of being accomplished. I will be personally accountable for follow-up through. And I trust that all stakeholders will support me in this task.

My thanks to you all.

Mr. Duale Adam Mohamed
Director General of Directorate of Health

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ACRONYMS

ABB	Activity Based Budgeting
AIDS	Acquired Immunodeficiency Syndrome
AUSAID	Australian Government Overseas Aid Programme
C4H	Communications for Health
DFID	Department for International Development UK
DPT	Diphtheria, Pertussis and Tetanus
DOH	Directorate of Health
EPHS	Essential Package of Health Services
EPI	Expanded Programme for Immunization
FAO	Food and Agriculture Organization
FGM	Female Genital Mutilation
FSNAU	Food Security and Nutrition Analysis Unit
GAVI	Global Alliance on Vaccines Initiative
GFATM	The Global Fund to Fight Aids, Tuberculosis and Malaria
HC	Health Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSAT	Health Sector Advisory Team
HSC	Health Sector Committee
HSSP	Health Sector Strategic Plan
HSSPFG	HSSP Financier Group
IDP	Internally Displaced Person
JAR	Joint Annual Review
JHNP	Joint Health and Nutrition Programme
MCH	Medical Centre Hospital
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NGO	Non-governmental Organization
PHU	Primary Health Unit
PPP	Purchasing Power Parity
RH	Regional Hospital
RHC	Referral Health Centre
SIDA	Swedish International Development Cooperation Agency
SRDP	Somali Reconstruction and Development Programme
TB	Tuberculosis
TFG	Transitional Federal Government
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nation Children's Fund
UNSAS	UN Strategic Assistance for Somalia
USAID	United States Agency for International Development
WATSAN	Water and Sanitation
WFP	World Food Programme
WHO	World Health Organization
ZHSCG	Zonal Health Sector Coordination Group

1. EXECUTIVE SUMMARY

The health of the people of Somalia remains in a critical situation with some of the worst health indicators in the world. Under-5 mortality is very high (in the range of 180 to 225 per 1,000 live births) and there has been little or no progress in reducing child mortality in the last 20 years. The WHO estimates that 61 per 1,000 newborn infants die within the first month of life, the highest neonatal mortality rate in the world. Similarly maternal mortality is among the highest in the world, at least 1,400 per 1,000,000 live births.

Recent assessments show high levels of malnutrition across Somalia[i] with famine declared in July 2011 in parts of south Somalia. On-going insecurity, lack of government access and limited coverage of health care services across most of the regions of Somalia, coupled with the absence of essential health, nutrition and water, sanitation and hygiene (WASH) facilities, is resulting in high levels of ill-health and frequent disease outbreaks. A situational analysis shows that the major determinants of population health are poverty, lack of security, lack of access to health services, poor nutritional status of the population, the low status of women and high rates of female genital mutilation, high fertility, low immunization rates, lack of access to potable water and safe sanitation, poor health behaviours and - increasingly - unhealthy life styles.

Given this challenging health situation and the recent development in the political process, the Health Sector Strategic Plan (HSSP) is an important step in building the Somali government's capacity to improve access to health services for the people of Somalia. The plan establishes a realistic and clear framework for allocation of national resources as well as a means to improve the allocation and effectiveness of external support for the sector.

The HSSP takes a pragmatic approach to the provision of essential services across South Central Somalia recognizing the current situation of near collapse of health services in some areas coupled with humanitarian and emergency needs. The priority is to consolidate and maintain essential services in all areas where access and security permits. The Directorate of Health will work with local and international organisations through cooperation agreements to continue and expand service coverage and quality for basic health care needs. Secondly, the Directorate of Health will begin to roll-out the Essential Package of Health Services (EPHS) through pilot districts across the regions with coordinated international support. Health promotion, WATSAN and environmental health are considered important areas of focus and this will include school-based education and communication work. The approach will require better coordination of all humanitarian and development agencies in the health sector and better use of available resources.

The plan provides the basis for the Directorate of Health to develop annual work plans and budgets; these will detail the specific activities and funds needed to accomplish the annual milestones set out in the strategy. The plan also provides a statement on government priorities for investment; thus support of funding and implementation partners can be better aligned and harmonised to be most effective and efficient. Government and donor responsibilities for implementation, management and reporting are set out and these will lower

the transaction costs associated with development cooperation. A monitoring system is included to measure progress in implementing the HSSP; this will be revised regularly, based on good evidence of what works and on changes to a rapidly evolving health sector.

Development of the HSSP took place between April 2012 and January 2013. A Strategic Planning Task Force led this process, chaired by the Director General, Directorate of Health, and comprising of senior staff of the MOH, representatives of the private sector and health provider groups, and staff of UNICEF, UNFPA and WHO. International consultants assisted the Task Force with technical information, tools and facilitation of workshops.

This HSSP responds to the most urgent health systems development challenges; it is the first post- conflict plan to build effective health sector institutions as well as core planning and financing systems in Somalia. Whilst this process is underway, it is essential that programmes to address vaccine-preventable diseases, tuberculosis, under-nutrition and HIV/AIDS, WATSAN, environmental health, for example, continue. The plan provides a framework for future programmes to work within, expanding access to quality services, encouraging better targeting of disease-specific programmes, better coordination of this work with government strategic priorities, and more effective use of external support. The Plan also acts as an overarching framework for the numerous sub-sector strategies and plans that have been, or are in the process of being, developed.

Management and planning of the health system is poorly developed. A central ministry and eleven Regional Health Teams are responsible for the health sector. A small planning unit is tasked with system-wide development, but most managers in the Directorate of Health are occupied with donor-funded projects. There is no health planning and budgeting system. The result is that decisions on health sector programming and funding are often made by international agencies with little or no involvement and consultation with the Directorate of Health.

There is a severe shortage of qualified health staff of all disciplines - medical doctors, nurses, midwives and other cadres. Community Health Workers provide a limited service in rural areas; this will need to be expanded as well as developing facility-based services at health centres, referral health centres and hospitals. Coverage of public health services in rural areas, and for nomadic populations, is very limited; it is estimated that less than 15% of the rural population has access to any health provider. Immunisation rates remain low and a skilled provider attends fewer than 20% of births. Current confidence in, and access to, the health system is very low; the strategic plan emphasises the need for building the capacity of the health system, dialogue with citizens and building confidence in the services as they become available.

By far the majority of ill people, if they can afford it and they live in an urban setting, secure treatment from the unregulated private sector. There is a growing commercial health care service sector, mostly providing diagnostics and pharmaceuticals. The quality of care provided by private providers is variable and often poor. Private providers are

concentrated in the major urban areas, resulting in great disparity in access to healthcare between towns and rural areas. Nonetheless, commercial health providers are important players in the health sector in South Central Somalia and cannot be ignored in any strategy for health sector development. There is an urgent need for research of this sector and design of innovative and practical public-private partnerships to harness its potential.

Nominally, the government provides health services through a four-tiered system – Regional hospitals, Referral Health Centres; Health Centres and Primary Health Units all providing at least some elements of a package of preventive and curative services known as the EPHS. Most services comprise of basic primary health care and outpatient services, and cater to women and children. Public sector service points are often managed, financed and at least partially staffed by employees of international or national NGOs and CBOs.

Critical medicines and consumables are externally financed and procured. UNICEF provides a regular donation of an "MCH Kit" to Referral Health Centres and Health Centres and a "community heath kit" for Primary Health Units. UNFPA provides a small number of reproductive health kits to Referral and Health Centres. WHO procures TB drugs and anti-retroviral treatments using Global Fund grants. Gaps are filled by NGOs and private donations. There are regular stock outs and shortages.

To pay health workers a living wage requires supplementation of their salaries by donors giving grants to NGOs and UN agencies. Improvements to physical infrastructure are also carried out through these grants.

Management and planning systems in the sector are inadequate. The Directorate of Health and the eleven Regional Health Teams (RHTs) are meant to be responsible for planning and managing the public health sector, but at present there is no effective planning and budgeting system. As a result, the UN often leads on deciding the priorities, programmes and allocation of funding to the health sector. Considerable investments are still made in emergency responses that are independently financed and planned by the UN Office for the Coordination of Humanitarian Affairs.

Information for planning and management is scarce, of uneven quality and incomplete. A health management information system (HMIS), supported by the Global Fund, managed by UNICEF and implemented by a contractor, collects some basic information on service statistics (mainly activity/diagnosis) from a few hospitals, Referral Health Centres and Maternal and Child Health Centres, with some basic information from a few Primary Health Units. HMIS data are currently rarely used in planning. Somalia has not undertaken a population census, it has no vital registration system and has little epidemiological or population based data. South Central Somalia was not part of the 5-yearly UNICEF Multi-Indicator Cluster Study, undertaken in 2011.

External support is the mainstay of financing of the public health sector. In South Central Somalia emergency assistance absorbs a considerable proportion of donor assistance; other disease specific programmes, such as those for polio eradication, malaria and HIV/AIDS are also the currently receiving a high proportion of funds. The World Bank concludes, "donors' funding for public health in

Somalia over the past decade could have been used more strategically. Better coordination among donors, local authorities, and implementers is now needed to avoid the mistakes of the past and to ensure that priority setting for future interventions is more evidence based and more results oriented." [ii]

As security across South Central Somalia is now improving and more areas are coming under government control, attention is now being given to transitioning the chronic/post-conflict health system from one that focuses on responding to emergencies to one that responds to peoples' everyday health needs.

The policy environment is beginning to improve with the production of a draft National Health Policy. A legal framework is absent and needs development urgently. The quality and coverage of the HMIS is improving. A number of strategies and/or programmes that have been developed for Somalia, particularly those for reproductive health, nutrition and mental health, are also useful.

Finally, there is increasing external assistance to the health sector from international health partnerships, traditional bilateral donor agencies, especially DFID, SIDA and AUSAID and from other countries including Turkey and Qatar. Consistent support is coming from the UN family. However, because external funding is neither routed through nor reported to the government, it is not known how much of this is spent in South Central Somalia.

The capacity of the Directorate of Health to carry out its core functions is low. A simple scoring exercise found that its capacity in policy formulation, strategic planning, and health services financing was "minimal". Capacity in human resource development, coordinating health services and providing services was a little better, "less than adequate" or "adequate".

Against this background, the Strategic Planning Task Force developed a four-year strategy to begin to establish a viable public health service in Somalia, the Health Sector Strategic Plan, .

From the start, it was decided that the HSSP should be first and foremost a plan to strengthen the health system in Somalia. It is not meant to be a comprehensive amalgamation of the many disease-specific plans and strategies produced by external agencies and international consultants. Rather than repeat these strategies, it instead responds to the most urgent health systems development challenges. It is a plan to build effective health sector institutions, planning and coordinated financing systems in Somalia. The HSSP provides a framework for existing vertical and disparate programmes to work within a strengthened health system, expanding access to quality services, whether public or private, encouraging better targeting of disease-specific programmes, better coordination of this work with government strategic priorities, and more effective use of external support.

The HSSP process began with developing a vision that the MOH would like to see accomplished by the end of the Strategic Plan. The Vision of the Somalia Health Strategy is to:

"Have a healthy and productive population contributing to the development of the nation".

The Strategic Planning Task Force then developed a Mission that will achieve the Vision, if accomplished. The Mission of the Somalia Health Strategy is to:

"Ensure equitable, affordable, and effective essential health services to all people in Somalia".

The Strategic Plan has six strategies that need to be addressed to achieve the Mission of the Strategic Plan. These are based on the WHO building blocks of a well-functioning health system. They are the broad areas of work that need to be addressed to accomplish the Mission. **In order of priority, they are:**

1. Leadership and governance: Strengthen the capacity of the Directorate of Health to have more effective leadership and good governance in the health care delivery system in Somalia.

The Directorate of Health will implement as a matter of priority a leadership and management development programme that has already been designed and agreed. The draft National Health Policy will be finalised and an annual planning, budgeting and reporting cycle to implement this strategic plan will be introduced. Harmonization of external support to the health sector through a new government–donor coordination system will begin. Improved citizens' engagement in the management and financing of the health services will be built through health boards and committees. The leadership and governance programme aims to equip the senior management level with the skills and tools to better regulate and manage the health system across the country.

2. Human Resources for Health: Increase the health workforce, improve their skill balance and strengthen their capacity.

The Directorate of Health will focus on developing a human resource policy and development master plan, designing and keeping an up-to-date record of all public health workers, their place of work and their qualifications and agreeing a standard remuneration package (e.g. meeting per diems, hardship allowances and performance bonuses) and require all donor agencies and NGOs to adhere to these standards.

The phased roll out of essential services is dependent on having sufficient qualified health staff. For this reason, human resources issues are high priority in the HSSP. It is urgent to improve access to qualified health providers in rural areas. The Directorate of Health will develop and implement a comprehensive workforce development plan with long term perspectives and strategies that will promote health worker deployment in more rural districts.

3. Service Delivery: Roll out the provision of equitable health services and functional health facilities in all regions.

This is the core activity of the Plan for the next 4 years and accounts for the major portion of the HSSP budget.

The Essential Package of Health Services (EPHS) was designed in 2009 and is widely endorsed. It comprises of:

- Four levels of service provision
- Ten health programmes
- Six management components

The four levels of services provision are:

- The primary health unit(PHU)
- The health centre(HC)
- The referral health centre(RHC)
- The hospital(H)

The EPHS is divided into10 programmes. There are six core programmes that are found at all four levels and four additional programmes that are found only at the referral levels. The programmes are then sub-divided into sub-programmes with standardized interventions. The EPHS includes 53 interventions related to nutrition, integrated across all the programmes.

The six core programmes are:

- Maternal, reproductive and neonatal health
- Child health
- Communicable disease surveillance and control, including WATSAN (water and sanitation) promotion and environmental health
- First aid and care of critically ill and injured
- Treatment of common illness
- HIV, STIs and TB

The four additional programmes are:

- Management of chronic disease and other diseases, care of the elderly and palliative care
- Mental health and mental disability
- Dental health
- Eye health

The Directorate of Health will implement this strategy in phases, with a focus on ensuring basic health services in all regions where access and security permit and a more comprehensive phase 1 EPHS in selected pilot districts in 4 regions. New EPHS district plans in all regions will be added each year so that by the end of the Plan all regions will be included. Comprehensive mapping of health resources will be undertaken.

To implement this strategy the Directorate of Health will *award contracts* to international or national private sector organizations to manage the roll-out implementation of the EPHS. Contracts will include contractual obligations linked to M&E, reporting and coordination. Contracts will be results based, with an emphasis on capacity building. The Directorate of Health will "host" in its building in Mogadishu a contract management group comprising consultants and MOH staff to oversee these contractors and to build the capacity of the Directorate of Health in performance and output based management. This arrangement will take some time to develop and implement, but ultimately it will reassure the donors that their support will be used effectively and build confidence for future investments. There should be a

planned reduction or withdrawal of external service providers in the long term, possibly towards the end of the HSSP, as the capacity of the Directorate of Health to manage services is established.

In order to ensure that existing external actors are contributing to the strategies in the plan, the Directorate of Health will develop and agree memoranda of understanding (MOU) with NGOs that are already supporting basic health services and the EPHS. These will include an agreement to provide the standard EPHS core programmes, use the agreed remuneration package, and adhere to common systems of reporting.

To improve the harmonization of external support, and improve the efficiency of health services, the Directorate of Health will negotiate with funding agencies such as the GFATM to gradually integrate TB and HIV/AIDS programmes into the EPHS. This will also reduce the transaction and management costs associated with these programmes.

4. Health Financing: Develop health financing system which relies more on national financing and community based resources, that allocates budget to priorities, accounts for spending accurately and uses national and international funds more efficiently.

There is currently no consolidated figure of the "resource envelope" for health. Some external financing is organised through a joint arrangement, the Joint Health and Nutrition Programme (JHNP) and other support is provided bilaterally to fund infrastructure, training courses and disease-specific interventions. As yet, there has been little investment in government management capacity, health systems development or in integrated services. There is very little data available to government on actual funding or expenditure for health across South Central zone from donors and UN agencies.

During the HSSP period, the Directorate of Health will work with the Ministries of Finance and Planning to increase the share of the national budget spent on health to reach 7% by the end of 2016.

The Directorate of Health will collaborate with the international community to set up a reporting system and database of funds being committed to and spent on health. The government will initiate more robust analysis of health financing though National Health Accounts and expenditure tracking. The Directorate of Health and other ministries will also work with the donor community to improve harmonisation of external finance through establishing a more effective government–donor planning and consultation process. Improving harmonization will be a crucial step to designing an approach where government and donor funds are allocated to the priorities in this strategy.

5. Medical Products and Technologies: Ensure provision of appropriate and sufficient medical products and technologies.

There is a large and unregulated import and retail business of pharmaceutical and health products in Somalia. Addressing the issue of the quality and safety of the medicines and other products that are brought in and sold in the private sector is a

priority and will begin with adapting other countries' registration systems for importers of health products, introducing administrative requirements that must be adhered to in order to import medicines and other products, and controlling who can retail them. The capacity of the Directorate of Health to manage and distribute donated supplies in the public sector will also be improved. The Directorate envisages much of this work will be managed through Public/Private Partnerships or contracted out.

To improve the efficacy and safe use of medicines and health products, the Directorate will develop and enforce the use of rational drug use guidelines in the public health service, and later encourage its use in the private sector by establishing public private partnership arrangements to encourage the private sector to provide quality health services.

6. Information and Research: Establish a comprehensive monitoring and evaluation system and research capacity.

The government will expand the reporting of HMIS data to all functioning public health facilities and some private health providers, improve data interpretation and analysis and produce annual Regional Health Reports for each region and a consolidated Zonal report. Annual facility surveys and a bi-annual household survey are planned in coordination with other zonal authorities.

The Directorate of Health will review and prepare an annual performance report that tracks progress against the indicators and milestones in the HSSP. A country wide Somalia Annual Health Sector Report will be developed through consolidation of common indicators in each zonal HSSP and discussed at a Joint Annual Review meeting.

Cost estimates

The estimated financing requirement for implementing the HSSP is $101million over 4 years, or approximately $25 million per year.

Actual total financing needs will of course be influenced by the performance of the economy at macro level, including inflation, exchange rate fluctuations and health service demand due to security improvement in South Somalia Region. Other important variables that would impact upon the total costs are population growth and migration dynamics, changes to the disease burden, and the success or otherwise of integrating the current vertical programmes into the EPHS. These variables will need to be assessed when annual work plans and budgets are being developed.

Risks

The management of risk is an important function of the Directorate of Health, particularly given the changing political situation in the country and transition from emergency assistance to more developmental support. A risk matrix has been developed that outlines external risks to the HSSP process and a risk management plan will be established that tracks changes and looks at ways to mitigate against the various areas of risk whether political, contextual, technical or institutional. **T**he HSSP is a first attempt at long term planning for the development of a public health service in post conflict Somalia, and as such it is a high-risk exercise, dependent for

its success on external support and goodwill and considerable efficiency improvements in contracting and implementation.

2. PURPOSE AND USES OF THE PLAN

The opportunity for the Somalia Directorate of Health to develop its first strategic plan for health legitimizes the role of government in the eyes of the people and reduces the potential for future conflict. The development of the plan has deliberately avoided unintended negative consequences for conflict by ensuring that all people in Somalia are able to benefit from the implementation of the strategic plan. The design of the plan aims to ensure that as security returns, all communities will benefit from improvements in health services. It acts as a framework for the transition from emergency humanitarian support to development assistance, improves the allocation and effectiveness of external support for the sector and sets realistic and understandable performance milestones.

This first South Central Somalia Health Sector Strategic Plan is an important step in building the government's capacity to improve access to health services for the people of Somalia. The HSSP sets realistic, measurable and understandable priorities appropriate to South Central Somalia, rather than setting unreachable global targets. A monitoring system is included to measure progress in implementing the HSSP and revising it based on good evidence of what works and what does not.

The HSSP recognises the role of the commercial sector and the growth of private purchase of health services in Somalia. The plan provides a guide for external investments in the health sector by traditional and non-traditional donors, the Somali diaspora, charities and NGOs.

The HSSP has three main purposes:

- It provides a strategic framework to guide the development of annual work plans and budgets that will detail the specific activities and funds that are needed to build a modern health sector and achieve the mission of the Directorate of Health. Annual work-plans and budgets will result in more focussed efforts by all partners and lead to better progress in the meeting the health needs of the people.

- It provides a clear statement to funding and implementation partners of the government's strategy and priorities for investment in the health sector so that the human and financial resources needed to implement the plan can be harmonised and external support, from traditional and non-traditional donors and from the UN, Somali diaspora and NGOs, can be made more effective and efficient. The plan also includes the design of clearer and more efficient donor-government responsibilities for implementation, management and reporting so that coordination can improve and the high transaction costs associated with South Central Somalia's receipt of international development cooperation can be reduced.

- New arrangements for the implementation of the HSSP provide clearer divisions of responsibility for implementation, management and reporting of the investment in, and the results of, the Plan. These

responsibilities are currently unclear.

3. THE PROCESS OF PLAN DEVELOPMENT

This began in April 2012 with informal consultations, initiated by the senior management of the MOH of the TFG at the time, with Regional Medical Teams, United Nations (UN) agencies and International and local NGOs.

A multi-sectoral Strategic Planning Task Force was formed in May 2012 chaired by the Director General, Directorate of Health (DOH), with members from the DOH and UNFPA, UNICEF and WHO, supported by full time national consultants. This group met on an irregular basis throughout May and early June. It then met full time for twelve days in June with a wide range of stakeholders from the UN, INGO and NGO sectors to produce a first draft of the plan, and a further three days in July to produce the second draft. Part time international consultants supported these meetings.[iii]

An early draft of the plan was circulated within the DOH for review and comment on the 10th June.

In mid-July, meetings were held in Mogadishu to refine the plan, the DOH having consulted on the early draft widely in the interim with health and nutrition sector agencies, with UN agencies and INGOs and with Non-State Actors (local NGOs and private sector health practitioners). [iv]

A two-day meeting of the Strategic Plan Task Force with the planning teams of the other two zones and the consultants was held in Nairobi 26-27 July. On the 28th July a group of representatives from UN agencies, donors and NGOs were briefed on the strategies of the Plan.

In January 2013 the DOH circulated the draft HSSP to Health Sector Committee Members and a further phase of consultations on the draft HSSP took place between the DOH and Regional Health Teams. This was followed by two weeks of planning exercises implemented by the Strategic Plan Task Force, again facilitated by the same international consultants and involving a range of stakeholders, especially from the UN agencies.

This phase was concluded in Nairobi with meetings among the DOH, the MOH of Puntland and Somaliland, donors and UN agencies.

4. THE EXTERNAL ENVIRONMENT

The determinants of population health

In developing the HSSP, one of the challenges was the lack of up to date and accurate data on many aspects of health in South Central Somalia. The 2011 UNICEF Multi-Indicator County Survey (MICS) did not include this zone. Various HMIS reports are now starting to emerge. A 2007 WHO Country Profile, a joint UN Reproductive Health National Strategy & Action Plan 2010-2015, A WHO/UNICEF/WFP/FAO/FSNAU2010 Somali Nutrition Strategy 2011-2013 and a 2010 World Bank study of donor financing of the heath sector all provide useful information. There are many other ad hoc reports and strategy documents. As a result, there is general consensus on many of the key determinants of ill health in South Central Somalia and the other zones.

Poverty is widespread and many communities are still living in precarious security and livelihood situations. . Around 45% of the population is "surviving" on $1 PPP or less per day, and 73% on less than $2 PPP per day. [v] Somalia ranks towards the bottom of UNDP's Human Development Index, but is currently not officially assessed. Certain population groups, such as internally displaced people (IDPs) and nomadic communities, are poorer than the general population.

Financing of health services is inadequate to provide the EPHS to all people. The government and donor community spend less than $3 per annum per person on health, with out-of-pocket expenses - supported through diaspora remittances, extended family and clan financing systems - accounting for 70-80% of total health expenditure. There is no accurate picture of the amounts of traditional and non-traditional, diaspora, charity and NGO funding of health services. External funding does not always align with the main causes of ill health. There is no consolidation of the funds spent on health in South Central Somalia, by government, by donors or by people themselves.

Nutritional status of the population is very poor. Data from 2001 to 2009 show that over this period, the median rate of global acute malnutrition has remained at Serious (10 to <15%) or Critical (15 to <20%) levels (WHO Classification 2000), with a national median rate of 16%. The latest nutrition surveys by the Food Security and Nutrition Analysis Unit (FSNAU) show global acute malnutrition (GAM) rate in some areas of 15-22% and severe acute malnutrition (SAM) of 5-7%. National median rates of stunting are above 20%. New MICS data show that only 13% of infants are exclusively breastfed in their first six months of life with half of 0-2 year olds being bottle-fed. Only 2% of children certainly receive a high dose of vitamin A in their first year. Vaccination rates are generally very low.[vi] 60% of children under five are anaemic. Almost half of women of childbearing age are anaemic, a quarter are vitamin A deficient. There are high levels of iron, zinc and vitamin A deficiency. Nomadic communities and IDPs suffer the poorest nutrition status.[vii]

HIV/AIDS is currently not a major cause of illness and death. However, there appears to be a slowly worsening epidemic in Somalia and there is no room for complacency. Serological surveys of ante-natal women suggest that Somalia already has a generalized AIDS epidemic (>1% HIV prevalence) with a concentrated HIV epidemic in female sex workers (5.2% prevalence). Comprehensive knowledge about HIV prevention among young people is estimated at only 4%. Data on modes of transmission are not available, and information on risk behaviours is very limited. [viii]Only few studies have been conducted over the past two years analysing the principal drivers of HIV. These suggest that, as is universally the case, populations at increased risk are sex workers and their clients (who are mainly truck drivers and police and army personnel). It can be anticipated that increases in HIV prevalence will continue, simply because of the reservoir of infections in the general population and the low level of condom use. A behavioural study of vulnerable population within risk zones in Somalia has been started to assess risk behaviour, health seeking behaviour and HIV knowledge. Establishing the causes of HIV infection and designing an evidence-based and focussed response to the epidemic is critical. The considerable investments being made in HIV prevention and treatment need to be based on better evidence. [ix]

Lack of transport infrastructure is a major barrier to accessing health services and this is inextricably linked to the security situation that still exists. Public transport systems are almost non-existent in most areas, especially remote locations. There have been no precise calculations of how far or how long people have to travel to a public health facility.

The **status of women,** particularly in rural areas, is low. They have limited access to education and violence against them by their husbands is a common and generally an accepted fact of life. Early marriage is widespread, and female genital mutilation/cutting of one type or another is universal. Use of effective contraception is the lowest in the world, more or less 0% of married women in rural areas use an effective form of family planning. As a result, fertility is high, over her lifetime a woman can expect to have at least ten pregnancies and between 5 and 6 live births. She has a 1 in 20 to a 1 in 15 chance of dying as a result of her pregnancy.

Education levels are low, with a high proportion of women in Somalia having no education at all. Adult literacy rate across the country is 25%. The net primary school attendance rate is 23%. There is a strong correlation between women's education and health behaviours, care of their children and fertility. [x]

Access to potable **water and safe sanitation** is limited. 29% of the population use an improved water source and coverage of water treatment is 22%. Only 37% of the population uses any form of improved sanitation. Access to soap and hand washing behaviour also varies greatly between urban and rural people, with very low levels of both in rural populations. A population's hygiene behaviours, and its access to clean water and safe sanitation, are strongly correlated with its health status. Unsafe water, poor sanitation and hygiene are indirectly responsible for one in five child deaths. Major declines in morbidity and mortality in Somalia cannot be expected without improvements to water, sanitation, food safety and hygiene.

The population **density** is low in rural areas making the provision of static health services a costly approach to health services delivery, whilst the growth rate is over 3% per annum, meaning the population will double every 20 years and around half of the population will be under 15. Planning health services needs to take this into account.

Pastoralists represent a significant population group with unique health vulnerabilities and needs. Deprivation indicators around living conditions and nutrition are particularly high in these populations, with 99% of people in nomadic areas reported as being multi-dimensionally poor [xi].

Life-style behaviour is an important determinant of health. Damaging behaviours such as the lack of exercise, smoking, road safety and chewing "khat" are examples where considerable attention is needed in health promotion.

There is general agreement that as a result of these factors, many people in South Central Somalia are experiencing some of the lowest health indicators in the world. There are limited signs of any improvement.

Table 1: Key Health Indicators (for Somalia as a whole)

Indicator		**Sources**
Under 5 mortality	200/1000	UNICEF 2009
Infant mortality	119/1000	UNICEF 2009
Neonatal mortality	61/1000	UNICEF 2009
Maternal mortality ratio	1044/100,000	WHO/UNDP estimate
Children fully immunized by age 1	5%	UNICEF 2009
Use of modern contraception	<1%	UNICEF 2009
Total fertility rate	8- 9	UNFPA
Skilled attendance at delivery	33%	UNICEF 2009
Prevalence of FGM	98%	UNICEF/MICS 2006
Deliveries in a facility	9%	UNICEF 2009
Under 5s wasted	13%	UNICEF 2009
Under 5s stunted	42%	UNICEF 2009
Under-5 global acute malnutrition rate	15%	FSNAU 2012
Use of improved drinking water	29%	UNICEF/MICS 2010
Use of improved sanitation	23%	UNICEF/MICS 2009
Adult HIV prevalence	0.5 – 1.5%	various
Life expectancy	51 yrs	UNDP 2011

It is difficult to find any current and comprehensive data sets on the causes of child mortality in Somalia. While specific data for South Central Somalia are very sparse, wider data sets from Somalia as a whole give an indication of the current situation. UNICEF reported in 2011 that the main *direct* causes of under-5 mortality in Somalia are acute respiratory tract infection (including pneumonia) (24%), diarrhoea (19%), neonatal disorders (17%), and intestinal parasites/measles (both 12% although measles vaccination coverage has increased in the past few years, so the proportion of deaths from measles may be declining). Around a fifth of children's deaths are from "unspecified

causes", testament to the lack of detailed information of health. The latest figures for Somalia estimate that 61 per 1,000 new-born infants die within the first month of life, the highest neonatal mortality rate in the world, according to the WHO report World Health Statistics 2010.

The most important *underlying* cause of child death and illness is malnutrition (in 2006 the proportion of under-fives suffering from underweight was 36%, from stunting 42% and from 13 %). Unsafe water, poor sanitation and hygiene are indirectly responsible for 1 in 5 child deaths. Immunization coverage (1 year olds fully immunized) was only around 35% in 2007. DPT3 coverage in 2008 was 31% compared with 72% in Mozambique and 62% in Zimbabwe (UNICEF 2010). Fewer than 10% of infants are exclusively breastfed in their first 6 months of life. 60% of children under 5 are anaemic. [xii][xiii]

Fewer than 20% of women receive two doses of tetanus toxoid during their last pregnancy – and only a quarter of women are protected against tetanus. These figures represent the lowest vaccination coverage rates in the world. Fully 90% of births occur at home and are not attended by a skilled provider. Female genital mutilation is universal, adding greatly to the risk of a maternal death.

The social determinants of health are also critical to health outcomes

A Gender Equality and Social Inclusion (GESI) approach to health planning is particularly appropriate to Somalia because of its chronic/post-conflict scenario, poverty, low status of women, nomadic as well as internally displaced populations and clan based culture. However, little work has been done on this issue to date.

The HSSP acknowledges and identifies these factors as contributing to the poor performance of the health system, but ensuring that GESI is given a central role in the planning process is more difficult. Embracing a GESI approach entails the need for strong analysis of the root causes of discrimination, gender relations, local power structures among and between the different clans and political groupings, and decision making at the household and community level. It also implies sensitivity and understanding of local cultural and religious beliefs. Research is needed to develop a clearer understanding of the reasons for social inequity and the barriers that restrict access before strategies can be more responsive to bringing about positive social change and lasting impact.

The lack of credible data, community information and research, low capacity and the overall lack of resources are clearly hurdles; but there is an opportunity to begin a discussion of mainstream gender and social inclusion. This can be an advantage in the long run as the system's capacity is built and the concept has a better chance of being institutionalized. Additionally, a GESI approach within the health sector can be an appropriate tool in serving a wider purpose. By narrowing gaps between various social groups and reaching out to the marginalized, it can help to build citizenship and social cohesion, which is essential in a chronic/post-conflict scenario. It is also important to be cautious: in some cases reaching out to a particular group can create new tensions and boundaries and a return to violence. This may happen between clans or even within households,

affecting gender relations and a possible backlash on women. If benefits are perceived to be going to a certain group, there is a risk of exploitation of that group or an attempt to manipulate the system to gain the benefits without merit. These dynamics and possibilities must be considered before any intervention.

At this stage the following minimum components of a GESI approach can readily be incorporated into the HSSP's strategies:

Table 2: A GESI approach to the HSSP

Strategies of the HSSP	GESI component
1. Leadership and Governance	• A GESI approach can be incorporated in the next version of the health policy • Build capacity within Directorate of Health to understand GESI issues
2. Human Resources for Health	• The HSSP will ensure adequate numbers of female service providers • Recruiting staff from clans/groups on equitable basis will be considered as feasible • Job descriptions can be revised to emphasise equitable service delivery and counselling skills
3. Health Services	• GESI can be made a criteria when awarding contracts • With EPHS as the platform, equitable service delivery will be made a priority • Strategies tailored to the needs of the population will be adopted - mobile clinics, or using entry points outside the health sector if they are culturally more acceptable
4. Medicines and consumable	• The Directorate will try to ensure that medicines and consumables which are donated are done so based on need and equitably
5. Health Financing	• Gender responsive budgeting will be phased in
6. Health Information	• Wherever possible, data will be disaggregated • GESI process indicators will be introduced to M&E systems such as the HMIS • Social audits will be used where possible • Research into barriers and health promotion activities for marginalized and under-served will be undertaken

Performance of the Health System in Somalia

The response to the main social determinants of ill health by the health system in Somalia is very poor. Progress in "improving the health status of individuals, families and communities" has been minimal in the past 20 years. Using the WHO criteria of what defines an effective health system, the government's capacity to "defend the population against what threatens its health" – natural disasters, under-nutrition, poor sanitation and hygiene, poor quality medicines and private health services, unhealthy traditional practices such as FGM, communicable diseases, high fertility and accidents – is extremely limited. Access to "people-centred care" is poor and communities have little say in decisions affecting their health and health system.

There is no comprehensive health promotion programme, with the exception of some public information surrounding Child Health Days and other vertical programmes. Small programmes are underway to promote breast-feeding and birth spacing and diarrhoea treatments; a programme to deter FGM has started. In contrast, marketing campaigns by private ventures??? to encourage mothers to feed babies formula, and the marketing of cigarettes and khat, all very harmful behaviours, is ubiquitous.

There is a severe shortage of qualified health staff and low efficiency among those that are employed. Under and over-staffing, low workloads and absenteeism are all problems. Health staff often have at least two jobs, and most public health doctors practice privately. There is an overall shortage of nurses and midwives. There is a chronic shortage of Community Health Workers, and those present are mostly facility-based, providing a very limited service in rural areas. The capacity to produce more trained health providers for the public sector is very constrained. Currently, there are seven private medical schools, seven nursing schools and one public school of midwifery. The work of these schools is not well coordinated. The quality of education in these institutions is not known. Total enrolment is low for the demand in the country and production is not regulated. Currently none of the training schools are accredited.

There is considerable inequity of access to public and private sector health providers, with services readily available to rich urban dwellers and almost absent for poor rural populations, internally-displaced people and nomads. Coverage of public health services in rural areas, and for nomadic populations, is very limited or non-existent. It is estimated that a skilled provider attends fewer than 10% of births with the remainder delivered at home with no attendance. Despite the very high burden of disease, consultation rates for children and adults are very low, with adults visiting a health facility once every eight years, and children under five visiting once every five years. Even functioning hospitals are very underutilised.

By far the majority of ill people, if they can afford it, secure treatment from the unregulated private sector, comprising of a mix of traditional and modern commercial providers. The role of the private sector in health services provision is so large that it cannot be ignored, but there is little hard data to use. In urban areas people regularly buy drugs direct from pharmacies. It is not known if out of pocket expenses on treating ill health are a cause of household poverty. The quality of care provided by private providers (traditional and

allopathic) is variable, but there is no comprehensive information on quality of health care in the private sector. However, the importance of the private sector to improving access to health services cannot be ignored; innovative ways have to be found to capitalise on the dynamism of the commercial health sector so it is able to provide good quality health services at affordable prices.

Pastoralists, who account for approximately 65% of the Somali population represent a significant group with unique health vulnerabilities and needs. Sedentary populations are largely confined to urban centres and southern river basins, whilst the majority of the rural population remains nomadic or semi-nomadic. Deprivation indicators around living conditions and nutrition are particularly high in these populations, with 99% of people in nomadic areas reported as being multi-dimensionally poor [xiv].

Healthcare seeking behaviour amongst pastoralists veers strongly towards the unregulated private sector, although access to both public and private services remains severely limited. A study undertaken in 2005 found that 38% of nomadic populations reported never going to a health facility. [xv] Vaccination coverage is low, particularly where repeat-contact is important, such as with DPT. Self-administration of medicines is common, with medicines being purchased in advance from private pharmacies.

Due to these unique supply and demand side challenges, innovative and locally responsive service delivery models must be implemented in order to provide acceptable and accessible health services to these populations. Learning from similar contexts in other countries should be utilised, such as outreach models which focus on taking mobile services to nomadic communities and which make use of linkages with interventions from other sectors, for instance livestock health and education.

The government health services system has four tiers. There are 8 referral hospitals,10 regional hospitals and 26 district hospitals, but none provide the range of tertiary care stipulated in the EPHS. There are 198 Health Centres (also referred to as Maternal and Child Health Centres, MCHs) providing at least some preventive and curative services, focused on women and children, together with basic health services for the general population, particularly in rural settings. There are 269 Primary Health Units (sometimes called Health Posts) that are supposed to provide limited curative, promotive and preventive services at the community level, but many do not operate. Even though the population is very dispersed, there are very few community health outreach programmes. Access to effective healthcare by rural populations, nomads and IPDs is extremely low.

Most public health services comprise basic primary health care and outpatient services. These services are managed by (mainly) international and (a few) national NGOs and CBOs.[xvi] Critical medicines and consumables for public sector facilities are externally financed and procured. UNICEF provides a regular donation of an “MCH Kit” to Maternal and Child Centres, and a “community heath kit” for Health Posts. WHO procures TB drugs and anti-retroviral treatments using Global Fund grants. Gaps are filled by NGOs and private donations. There are regular stock-outs and shortages in busy Health Centres, and over-supply in under-utilized facilities. To

pay health workers a living wage requires that salaries at all levels be "topped up" to one degree or another through donor grants to NGOs and UN agencies that then pay "incentives" to health workers at all levels, from Director Generals to cleaners. Improvements to physical infrastructure are drastically underfunded.

Overall, management, planning and human resource systems are very poorly developed. A central health ministry comprises around 90 employees (the exact figure of those actually working is not available) who are organised loosely into five directorates. There is a DOH Senior Management Team, and the departmental directors meet under the leadership of the Director General. The current organization arrangement is not appropriate for the implementation of a strategic systems strengthening programme. Senior staff skills, expertise, job responsibilities and reward mechanisms in the DOH are not designed to develop effective performance or accountability. Regional Health Teams (RHT) need to be established. An RHT is supposed to be supported by a Regional Health Board (RHB) intended to advise it, represent the community and to raise funds for local projects. Planning of health services needs to take into account variations in local politics, services and funding streams, but at present there is little capacity to plan health services in the regions.

The ministry has a very small operating budget of its own, no staff member apart from the Director General has any spending authority, and most salaries are paid by donors through UN and NGO executed projects. Staff effort is therefore focused on securing a livelihood from donor-funded initiatives, meetings and training opportunities. There is no planning and budgeting system to provide the framework for a leadership role for the Directorate of Health in managing better coordination of external support to the sector, to map out a transition from vertical to horizontal programming, or at a minimum, a more equitable or evidence-based allocation of resources. Funding allocations to the health sector in South Central Somalia are generally decided with little or no involvement of the Directorate of Health.

Information for planning and management is scarce, of uneven quality and incomplete. Service statistics are collected and analysed regularly through a GFATM-funded Health Management Information System (HMIS), but only from hospitals and some Health Centres in the public sector. There is little use of service data for planning and resource allocation. South Central Somalia has not undertaken a population census, has no vital registration system and has little epidemiological or population based data. Indeed, one of the major issues faced in developing the HSSP is the absence of robust community-level information for designing responsive health interventions, or macro-level epidemiological data on which to base realistic impact measures. Similarly, output targets, such as the coverage or utilization of health services, are of little or no value in South Central Somalia because of the lack of baseline data, the fragmentation of health information, the paucity of analysis of data that does exist and the uncertain future. There is very little good quality intervention-research information on health. There is no research capacity at the central or regional levels.

External support is the mainstay of financing of the public health sector in South Central Somalia, and this has been increasing steadily over the past decade. Emergencies absorb a considerable proportion of all donor assistance, with the Somalia Health Cluster operating largely independently of the DOH. It is estimated that less than a fifth of "official" donor support is invested in health systems development or "horizontal/integrated programmes". Levels of funding for some vertical programmes such as HIV/AIDS and malaria does not reflect the main causes of ill health, although grants for these diseases do include some support for health systems development. Nutrition, infant and maternal health, immunization and reproductive health programmes all remain underfunded. The World Bank concludes, "donors' funding for public health in the country over the past decade could have been used more strategically. Better coordination among donors, health authorities, and implementers is now needed to avoid the mistakes of the past and to ensure that priority setting for future interventions is more evidence based and more results oriented." [xvii]

As security and access improves, progress will be needed in transitioning the post-conflict health system from one that focuses on responding to emergencies such as malnutrition, disease outbreaks and immunization, into one that better responds to peoples' health needs. There are some opportunities in Somalia to move away from vertical programmes and campaigns to horizontal programming models and integrated services. Signs of change include:

- An **Essential Package of Health Service (EPHS)** has now been adopted as a reference point for all partners. Although the EPHS may be too ambitious for the current capacity of health services, the package does standardise the activities that should take place at each level of the public health service, and directs health authorities, health workers and health partners on how to bring about improvements in quality of service and care.

- The **policy environment has improved somewhat**. A draft National Health Policy for Somalia has been written. This is a comprehensive, though ambitious statement of policy intent. This requires approval by the Parliament. There is an urgent need for a number of policy and regulatory documents by the DOH. How such policies will be translated into law, and how laws will be enforced given the blend of traditional, western and Islamic legal systems that operate in Somalia remains a question.

- **UNICEF provides medicines and consumables in kit form, reasonably reliably and regularly to hospitals and MCHs**. There are long term plans to transfer the logistics of kit distribution to the DOH.

- **Service statistics** are now being collected from some hospitals and MCH Centres, and consolidation has begun. Analysis of, and response to, these at local, district and regional levels needs to be improved for effective health management.

- The international community has written a plethora of strategies and/or programmes for Somalia as a whole, though in a rather uncoordinated fashion. Amongst these

are:

- A Joint Health and Nutrition Programme (JHNP) supporting the Somali Health Sector, 2012-2016.
- Strategies for addressing HIV, TB (and malaria) from the Global Fund for AIDs, TB and Malaria (GFATM)
- An MOH (with support from World Health Organization, UNICEF, World Food Programme (WFP) and FAO/FSNAU) Nutrition Strategy 2011-2013 that is currently being translated into an action plan.
- A WHO Strategy for Mental Health in Somalia.
- A strategy for Health Systems Strengthening Support, 2010, produced by the GAVI Alliance.

- **There is increasing external financial investment in the health sector from international health partnerships**, such as the GFATM and GAVI, from bilateral donor agencies such as DFID, AUSAID and SIDA, Turkey, UAE, Qatar and from the UN. There is no consolidation of the total external financing for health that is committed to Somalia or that it has already received. Because external funding is not reported to any one agency, including the government, it is not known how much of this is spent in Somalia.

- **External investments greatly exceed government contributions to the health sector.** An average of US$100 million was provided annually to Somalia as a whole over the period 2007-2009. There is no figure for aid to health in South Central Somalia specifically. Vertical programmes absorb a large proportion of external financing and appear to reflect global priorities and new funding opportunities, for instance the emergence of GAVI and the GFATM. While important, these are not based on an analysis of the main causes of ill health. Programmes like polio, HIV and malaria receive substantial amounts of support, while programmes with greater public health significance (nutrition, reproductive and neonatal health and non-communicable diseases and accidents) continue to be underfunded. With the extremely high prevalence of TB and very low levels of case detection (estimated at only 38% - WHO 2010) more focused investment into an integrated public health service and community based case detection and care is required to make a significant impact on TB prevalence.

- Most recently, the governments of Australia, Sweden, the US and the UK have suggested that they might contribute part of a total of $250 million over five years that they calculate is needed to implement a Joint Health and Nutrition Programme. The World Bank has also been engaged in the process. Contributions to the sector are also coming from other countries, notably Kuwait, Turkey and Qatar. Sizeable contributions are also said to flow from the Somali diaspora. But information on the size and purpose of these funds is anecdotal; no accurate or comprehensive data is available. Most diaspora contributions are used for capital investments in health facilities and equipment, with little money for recurrent expenditures or health systems development.

- Out of pocket household expenditures, sustained by clan, family and remittances from overseas, are adequate to

support **a rapidly growing commercial health care services sector**, mostly providing diagnostics and pharmaceuticals with variable quality of care. Members of the diaspora often have free access to very high quality of care in their host countries, especially from the publicly funded services of the UK, Canada and Sweden. In Somalia, private providers are concentrated in the major urban areas. There are few quality services for marginalised communities, resulting in great disparity in access to healthcare between towns and rural areas. It is estimated that 80% or more of all health care expenditure is out of pocket. The fact that most people turn to the private sector for health care means that it may be offering more convenient, cheaper or more effective (in the perception of users) services than the public sector. Or it could imply that public health services are just inaccessible to most people. Either way, commercial health services (allopathic and traditional) are important players in the health sector in Somalia and cannot be ignored in any strategy for health sector development. The secret to success will be to incentivise the private sector to provide public health goods at affordable prices.

Summary

Somalia is under-developed and poverty is widespread. Population health indictors are amongst the poorest in the world. The public health system is poorly developed, externally driven, expensive and inefficiently planned, implemented and managed. There is a growing but unregulated private health services sector.

Funding, planning and supplying the public health system is almost entirely done by bilateral donors, UN agencies, and NGOs operating in a variety of "partnerships". These three core functions are planned with a short-term perspective and not well coordinated or harmonized. Most external agencies have intervened in a poorly researched and chaotic health sector in an attempt to develop a basic public health care system at community level. So far, this effort has generally fallen well short of expectations, so most Somali people turn to the private sector for health services, and pay out of pocket for care of variable quality and for medicines that are often sub-standard.

There is room for considerable improvement in the development of coordinated long-term strategies, work-plans, budgets and accountability by all stakeholders involved in the health sector.

5. CAPACITY OF THE DIRECTORATE OF HEALTH

The strategic planning process examined the capacity of the Ministry to conduct its core functions. The Planning Working Group allocated scores out of 10 (with 10 to 9 being excellent capacity, 8 to 6 being adequate capacity, 5 to 4 being less than adequate capacity and 3 to 0 being minimal capacity) to these functions.

- **Policy formulation: *less than adequate*.** The recent production of the (draft) National Health Policy and participation in a number of policy exercises suggests that the Ministry has some capacity to develop policies. However, the quality of these papers needs improvement before they can be useful to the Directorate of Health and its partners.

- **Strategic planning: *minimal*.** The Ministry does not have a strategic or annual plan to guide its work. It prepares an annual budget request (primarily for salaries) that is submitted to the Ministry of Finance each November for the following year, but otherwise there is no planning system. Few staff have skills in planning or budgeting.

- **Health services financing: *minimal*.** 85% of the Ministry budget is spent on salaries; it has no capacity to invest in the development of the health system, or to implement any of the minimum activities that are the normal responsibility of a Directorate of Health.

- **Coordination of health services: *Less than adequate*.** A quarterly coordination meeting of NGOs and UN agencies is held occasionally, but funding and programming decisions, particularly of UN agencies and internal health partnerships, are taken at other meetings, held mainly in Nairobi. None of the state's major donors are represented in Mogadishu. External financing of public health services is done largely independently of the Ministry and there is no consolidated financial recording system.

- **Service provision: *Less than adequate*.** The capacity of the Directorate of Health to provide and manage services is weak; its budget is too small, it has too few facilities and employs too few staff to provide a reasonable level of services, especially to rural and nomadic populations. It relies on the UN and NGOs for supplies of essential medicines and consumables. There is no government procurement system.

- **Human Resource development and management: *less than adequate.*** Despite the ministry's effort to hire new talents some of which are recent graduates' from local universities and some experienced from the diaspora, the Ministry's HR systems are very weak. Staff are underpaid and poorly motivated, although salary supplementation, on the job training and supervision and some ad hoc in-service training takes place. There are no job descriptions, no career development schemes, and no system of accreditation or performance management.

6. THE VISION OF THE HEALTH STRATEGY.

The vision of the Health Sector Strategy for South Central Somalia is to:

"Have a healthy and productive population contributing to the development of the nation".

The Vision encompasses two important points: first, "healthy and productive". This emphasises that healthy population create and maintain opportunity for good health to assure people are not falling into poverty. It also means that the Somali population are contented customers of health services, whether public or private, but that ability to pay does not exclude people from access to quality services.

Second, there is an emphasis on "development and contribution". Recognizing healthy and productive people yield to productive payoff, a focus of the vision should be improvements to the development of the nation in response to more than twenty years of conflict that resulted, among other things, the health services in Somalia to be the lowest in the world. It further sees an opportunity for healthy and productive people can contribute to the overall development of the nation.

7. THE MISSION OF THE HEALTH STRATEGY.

The Strategic Planning Task Force then developed a Mission that will accomplish the Vision, if carried out successfully.

The Mission of the Somali Directorate of Health is to:

"Ensure equitable, affordable, and effective essential health services to all people in Somalia".

The Mission captures three important ideas:

First, the Ministry acknowledges that given its limited capacity and resources, the focus of the plan in the next three years should be on "building an effective health system". This captures the idea that the focus in on strengthening the core functions of the Ministry to lead the health system.

Second, the mission focuses the Strategic Plan on "essential health services". The intention is to spend the period of the strategic plan expanding access to the services that comprise the six core elements of the Essential Package of Health Services (EPHS).

Third, once again, the Plan will not discriminate in its efforts to ensure the provision of the EPHS; the Mission has equity at its core. However, given current capacity and the scarcity of resources, equity will be a slow and gradual process, it is simply not possible to ensure equality of access for all people immediately. One of the key factors that will influence progress in delivering the strategic plan objectives will be the access and security across the country. Currently large areas of Somalia are still not under the control of the Federal Government and this will continue for some time. As security increases and government has more access, the health sector plans can be increasingly rolled out.

8. STRATEGIES TO ACCOMPLISH THE MISSION

The Strategic Planning Task Force developed six strategies that need to be addressed to carry out the Mission of the Strategic Plan. The Task Force used the WHO building blocks of a well-functioning health system as a framework for this stage of the plan.

Strategies are the broad areas of work that need to be addressed to accomplish the mission of the HSSP. They are the packages of work that need to be undertaken to translate the mission into reality.

Donors and UN agencies have supported the delivery of many disease-specific vertical programmes. Each of these programmes (HIV/AIDS, TB, polio, MCH, reproductive health etc.) along with other health related interventions such as nutrition and humanitarian responses all have detailed strategies, plans and interventions. In each of these programmes there are components of the six building blocks of Health System Strengthening that are outlined in this document. The HSSP is intended to harmonise and align each of these programmes within the overall framework of the HSSP to ensure that national priorities are also reflected within each of the separate vertical programmes.

Health services: The DOH will improve the quality and increase the use of the essential package of health services, with a focus on women and children.

This strategy is the core activity of the HSSP for the next four years. It involves a major effort to transition from emergency humanitarian actions to the systematic roll out the EPHS to regions, to improve nutrition services for vulnerable groups and to pilot innovative ways of harnessing the commercial health sector for the public good.

Piloting the EPHS has taken place in Regions in other zones such as in Sahil and Kakaar with support from the UK government's Health Consortium Somalia Programme. Early work is also starting under the same programme in Gedo Region. From 2013 there will be a phased roll-out of EPHS so that by 2016 all regions will provide a basic package of EPHS core programmes and 4 regions will provide a full EPHS programme.

UN agencies and donors, the Federal Government health authorities and other stakeholders support the design of the EPHS. The EPHS is in line with the UN Strategic Assistance for Somalia (UNSAS). The EPHS includes interventions that address all but one of the interventions of the Basic Nutrition Package, HIV/AIDS prevention and care, TB services and mental health services. [xviii][xix]

The Directorate of Health will implement this strategy in phases, with an initial focus on Banadir, Gedo, Galgudud and Lower Shabeele regions from January 2013 to December 2014, during which time it will seek additional support from the donor community to expand the programme to the remaining seven regions (Mudug, Hiraan, Middle Shabeele, Bay, Bakool, Middle Jubba and Lower Jubba) no later than January 2014 onwards.

The intention is to maintain basic health and nutrition services (the Basic Nutrition Services Package plus obstetric care, Child Health Days and the "Reaching Every District"

strategy) in regions where the EPHS is not yet implemented. Work will also be undertaken to introduce behaviour change campaigns and to improve school and environmental health. Research will lead to piloting innovative partnerships with the commercial health services providers.

To implement this strategy the DOH will undertake three areas of systems development work:

- The DOH is reviewing evidence from countries that have contracted the provision of health services ("in" or "out") with private sector agencies (NGOs or management companies) as one means to increase access to essential health services. Two such countries, Afghanistan and Cambodia, both in post-conflict transition, have identified increase in service access using this method of service provision. Evidence from the Health Consortium Programme where a management agent and NGOs are "contracted in" by DFID to provide the EPHS in selected regions also shows that - in a post-conflict situation - such an arrangement can have good results. If the DOH finds sufficient evidence in support of this method of service provision, it intends to develop the capacity to *award contracts* to organizations (international or national) to manage the implementation of the 6 core components of the EPHS for health services delivery in the 4 initial Regions. Contracts will be results based, with an emphasis on capacity building of the public health system and "lesson learning." The DOH intends to "host" in its building in Mogadishu a contract management group comprising consultants with experience of this arrangement and MOH staff to oversee the contractors and to build the capacity of the DOH in performance and output based management. This transition arrangement may take some time to effect, but it will reassure donors that their support will be used effectively and build confidence for future direct investments. There must be a planned withdrawal of external service providers in the long term as the capacity of the state to manage services is developed.

- To ensure that existing contractors are contributing to the strategies in the plan, the DOH will develop and agree memoranda of understanding (MOU) with NGOs that are already supporting the EPHS. These will include an agreement to provide the standard EPHS core programmes, pay common salaries and incentives, and adhere to common systems of reporting. Later, new contracts can be developed and agreed using these criteria.

- To improve the harmonization of external support, and the efficiency of health services, the DOH will negotiate with funding agencies such as the GFATM to gradually integrate TB and HIV/AIDS programmes into the EPHS. This will concurrently reduce the transaction and management costs and increase the value for money associated with these programmes.

Health financing: Develop a health financing system which relies more on national financing and local resources, that allocates budget to priorities, accounts for spending accurately and uses national and international funds more efficiently through a Sector Wide Approach.

There is currently no consolidated figure of the "resource envelope" for health in South Central Somalia. The total investment is impacted greatly by funds mobilized through the Common Humanitarian Fund (for Somalia) for emergency contracts awarded by the Health Cluster, led by the WHO. For the period 2013-2015 the cluster is seeking a total of $260 million, (with an additional $373 million sought for nutrition by UNICEF). This is a major source of funding for health and nutrition and is implemented through UN agencies and through a large number of contracts with local and international NGOs. Most external financing is organised bilaterally, rather than being "pooled" in any way, to support disease-specific interventions – for example, polio control, HIV prevention and care, immunisation, malaria and TB. There is very little investment in development in management capacity, in health systems development or in integrated service provision. Without more financing, improved coordination and targeting of existing financing, and a renewed focus on value for money and results, the vision and mission of this strategic plan cannot be accomplished.

During the Plan period, the DOH will focus on four areas:

- The DOH will work with the Federal Government Ministries of Planning and Finance to increase the share of the national budget spent on health by one percentage point a year to reach 7% by the end of the Plan. The DOH will also explore other ways of generating additional funding for health, such as expanding voucher systems, taxing cigarettes and Khat, 'health income remittances/donations' from the diaspora, charging fees for health providers to register and recovering costs from individuals using public health services who can afford to pay.

- Calculating what is spent on health and where resources come from is a relatively straight-forward health accounts exercise. The DOH will work with the international community (donors, UN and NGOs) to set up a reporting system and database of all funds being spent on health in South Central Somalia. This is a major area of work that will require international technical support to develop and implement and coordination with other zones.

- In line with the Paris, Accra and Busan principles, the DOH and other ministries will work with the donor community to simplify and improve coordination mechanisms for external finance through establishing a more effective government–donor planning and consultation process. This should be based on direct meetings among government, donor and other agency representatives who are able to make programming and financial decisions. To reduce the time DOH representatives are away from their desks, working meetings will be held whenever possible in Mogadishu. It should also include an efficient follow up and accountability system. Improving harmonization will be the first step to designing an approach where government and donor funds are allocated to the priorities

in this strategy. This issue is discussed further in the section below on Implementation, Management and Reporting.

Human Resources for Health: Establish a skilled, well managed, motivated and equitably distributed workforce to provide ESH.

The DOH recognises how critical this strategy is for progress and will work to complete a Human Resource plan and policy as a matter of urgency, with generic job descriptions for all cadres. Work to implement these is required such that training, recruitment, retention, and motivation of health managers and service providers at all levels of the public service are strengthened. An HR training needs assessment must be undertaken and an HR database requires establishment. The DOH must work closely with the Civil Service Commission that holds the responsibility over civil servant human resource issues, to ensure the DOH has a voice in determining HR policy and strategy regarding health staff. The DOH will focus on five areas of work:

a) Drafting the human resource policy and development of a master plan. The DOH will collaborate with the Civil Service Commission in "right sizing" the DOH workforce, beginning with the civil service "census" of all individuals on the payroll.

b) Improving records of all public health workers, their place of work and their qualifications and incorporating this data into the HMIS.

c) Agreeing a standard incentives and allowances package (e.g. meeting per diems, hardship allowances and performance bonuses) and require all donor agencies and NGOs to adhere to these standards.

d) It is urgent to improve access to qualified health providers in rural areas. The DOH will work to train Community Midwives and plans to develop a special programme to deploy and retain skilled staff in rural and nomadic areas such that by the end of the Plan, 80% of rural health facilities are staffed by skilled health workers.

e) A "certification/accreditation" system for all public health workers will be developed to improve quality of work and motivation, ensure a systematic in-service training programme with set standards for health training institutions.

Medicines and Consumables: Improve the availability, quality, safety and rational use of medicines and health products

Three areas of work will focus efforts to achieve this strategy.

a) Addressing the issue of safety of the medicines that are sold in the private sector by adapting other countries' registration systems for importers of health products, introducing administrative requirements that must be adhered to in order to import medicines and other products, and controlling who can retail medicines.

b) Improving the capacity of the DOH to manage and distribute donated supplies in the public sector by working more closely with UNICEF and UNFPA to develop a more

responsive procurement and supply system that is based on an assessment and reporting system from all public health facilities.

c) Improving the use of drugs by clinicians through implementation of revised rational drug prescribing guidelines.

Health Information: Plan and manage the health system based on better quality up-to-date information, analysis and reporting

Three areas of work will be conducted during the lifetime of this plan.

a) Expanding and improving the HMIS to include all accessible and functioning public health facilities and some private health providers (possibly through an on-line reporting system), improving data interpretation and analysis and producing annual Central DOH and Regional Health Reports for the eleven regions of South Central Somalia. This will include surveillance and early warning systems, and an M&E system to track performance. Close collaboration across zones will be ensured.

b) Developing and implementing a population-based survey plan to generate information for programme design and management. Seeking better information on how to provide effective health services for hard-to-reach and nomadic populations will be included.

c) A number of ad hoc but critical studies and data collection schemes are needed. The DOH will partner with a research institution, develop a "research agenda" to establish priorities and build international and local partnerships to conduct priority research studies.

Leadership and Governance: Strengthen leadership and governance to better manage the core functions of the DoH at all levels

Four areas of work will be conducted during the lifetime of this plan.

a) The DOH will draft a Public Health Act and present it to parliament for approval and passing of a bill to govern all areas of health.

b) The DOH is already in the process of improving its capacity in leadership and management through a long-term in-service training programme that covers all of the main functions of the Ministry. This programme will be implemented during the time-period of the HSSP.

c) In addition, the DOH will institute an annual planning, budgeting and reporting cycle to implement its work. An important element of this new planning cycle will be improving harmonization of external support to the health sector through new government donor working arrangements. This is described in the section below on Implementation, Management and Reporting.

d) The MOH will study ways to work with the commercial health sector to improve service quality and access. It is too early to be specific regarding what exactly needs to

be done, so some research and pilots are required. Above all, it is essential to focus this work on incentivising private providers to contribute quality and affordable services to the health sector.

9. STRATEGIC PRIORITIES

Whilst acknowledging that all of these strategies are important to the development of an effective health system in South Central Somalia, if the DOH does not have the resources to accomplish all of these strategies, it will focus first on Strategy 1: Leadership and Governance. Without effective leadership and governance by the DOH, at a minimum of externally provided support, the health system will continue to be fragmented, inefficient, externally-driven and less than effective. The period of this HSSP will be critical in the stewardship of the transition from humanitarian to development approaches and establishment of new working relationships with all stakeholders in the sector. An important part of state building is government leadership to provide basic services for its population. Leadership and governance is the first building block in this process.

The second priority is to establish a trained, managed and motivated workforce to provide critical health services that respond to the population's needs. South Central Somalia needs to draft its human resource policy and plans, and agree a reward system that motivates and retains the workforce, particularly in rural and nomadic areas. Unless this is done, it will not be possible to improve access to quality public health services.

The third priority is to ensure the delivery of public sector health services, focussing on the Essential Package of Health Services. The government will rely on the goodwill of its development partners to support this strategic priority; in cooperation with the DOH and with each other, partners can ensure that access to the core interventions of the EPHS is expanded to as much of the population as possible. Working together will avoid duplication and improve the effectiveness of partner support by coming behind the Ministry's strategic priorities. Ways of working with commercial health providers will also be researched and piloted.

If resources are available, the DOH will address the fourth priority: putting in place a financing system that sees more funds coming from the national budget, securing extra-budgetary local funds, aligning more funding to identified priorities, and increasing the effectiveness of external support.

The DOH will address the problem of medicines and consumables. UNICEF and WHO are already providing assistance in supplying the public health sector with the required medicines. Thus, although the DOH wishes to make improvements in this strategic area, this will be done only if it has adequate resources for other priorities. Addressing the issue of unsafe medicines will also be undertaken if resources are available.

There is some information about the key determinants of health and health indicators to know where resources should be invested. More and better quality data for decision-making is needed and work will be started to develop this as resources become available.

10. S.M.A.R.T. OBJECTIVES TO ACHIEVE THE MISSION

The next step in developing this Strategic Plan was to formulate for each Strategy a series of S.M.A.R.T [xx] objectives that need to be accomplished if the Vision of the Strategic Plan is to be achieved. These objectives are what is possible, rather than what might be desirable.

Thus, in priority order, there are six strategies with accompanying objectives that must be accomplished to implement each strategy. Again, in priority order these are:

Strategy 1 - Leadership and governance: Strengthen the capacity of DOH to have more effective leadership and good governance in the health care delivery system in Somalia.

Objective 1: Establish a policy and legal framework for the health sector.
Objective 2: Establish effective planning and budgetary frameworks and processes.
Objective 3: Improve effective governance, leadership and management and institutional capacity at all levels of Directorate of Health.
Objective 4: Build community governance arrangements at Regional, District and Facility levels (Regional Health Committees, District Health Boards, Health Facility Committees).
Objective 5: Establish a framework for health sector coordination and partnership (at all administrative levels and including international development partners, INGOs, NGOs).
Objective 6: Establish agreements (contracts/MoU) with Service Providers that are supporting health services (including standards and reporting requirements).
Objective 7: Build emergency preparedness and response capacity within the national system.

Strategy 2 - Human Resources for Health: Increase the health workforce, improve their skill balance and strengthen their capacity.

Objective 1: Develop a human resources management policy and plan.
Objective 2: Establish revised standard remuneration levels and seek harmonization from all donor agencies and service providers.
Objective 3: Revive and strengthen health professional associations.
Objective 4: Train and capacity build for human resources to provide services in line with EPHS.

Strategy 3 - Service Delivery: Roll out the provision of equitable health services and functional health facilities in all regions

Objective 1: Basic EPHS (at least three core EPHS programmes), available in all regions by December 2016 (Maternal, reproductive and neonatal health; Child health; Communicable disease surveillance and control, including WASH promotion).
Objective 2: EPHS (6 core programmes) available in selected districts within accessible regions.

Objective 3: Strengthen and harmonize community service delivery capacity.

Objective 4: Develop national and regional referral capacity for obstetric and surgical emergencies and trauma (including blood banks and 4 additional EPHS programmes).

Strategy 4 - Health Financing: Develop a health financing system which relies more on national financing and community based resources, that allocates budget to priorities, accounts for spending accurately and uses national and international funds more efficiently.

Objective 1: Increase the proportion of the national budget spent on health to 7% by the end of the HSSP.
Objective 2: Establish (national) health accounts detailing all sources of health sector financing including from national budget, community/diaspora sources, external assistance and out-of-pocket expenditure.
Objective 3: Create a health financing framework to ensure adequate and predictable funding of the sector
Objective 4: Introduce a sound financial management and accounting system for the Directorate of Health.

Strategy 5 - Medical Products and Technologies: Ensure provision of appropriate and sufficient medical products and technologies..

Objective 1: Ensure that the quality of drugs and medical supplies to health facilities meet international standards for safety and efficacy
Objective 2: Promote rational use and management of drugs and medical supplies.
Objective 3: Improve the physical infrastructure, equipment and supplies in health facilities.
Objective 4: Introduce new (environmentally appropriate) technologies (solar, water catchment, waste management) in line with service delivery roll-out.

Strategy 6 - Information and Research: Establish a comprehensive monitoring and evaluation system and research capacity.

Objective 1: Further develop, design and harmonize the HMIS system.
Objective 2: Establish research capacity and health survey and research priorities identified.
Objective 3: Establish integrated diseases surveillance system.

11. RESULTS FRAMEWORK

The next step in the strategic planning process was to develop a Results Framework that includes specific milestones, year by year, designed to accomplish the objectives of the plan under each strategy. Indicators to measure the achievement of each objective are included that form the basis of the HSSP M&E framework. This will enable the DOH to revise the HSSP annually, depending on progress and lessons learned.

THE RESULTS FRAMEWORK

Results Framework	Baseline	Targets / Milestones			
	2012	2013	2014	2015	2016
Strategy 1	Leadership and governance: Strengthen the capacity of DOH to have more effective leadership and good governance in the health care delivery system in Somalia.				
Objective 1: Establish a policy and legal framework for the health sector	- No legal framework - No public health act - Drug policy development under preparation - International health regulation - Health Policy draft and agreed	- Draft Public Health act - Draft Drug policy - Draft Drug act - Health Policy document finalized. - Health regulatory framework - Draft WATSAN and Environmental Health policy and strategy - Draft C4H strategy	- Public Health Act adopted by Parliament - International health regulation adopted - Drug Act adopted by Parliament - Drug Policy adopted Dissemination of all Acts and Policies and orientation undertaken - Phased introduction of Regulatory framework. - Phased introduction of Minimum Service Quality Standards.	- Additional work on Acts and Policies	- Additional work on Acts and Policies
	Indicator 1.1 (Core)	**Number of Legal Acts and Policies published as specified in the HSSP**			
	Source	**DOH Annual Report**			
Objective 2: Establish effective planning and budgetary framework and processes.	- Draft Health sector strategic plan (with costing and with results framework). - Agreed annual health sector planning and budgeting process.	- HSSP finalised (January 2013) - Annual Work Plan and Budget (AWPB - 2013) in place (January 21013). - JAR and reportand agreed milestones for 2014 (aide memoire) - Annual work plan and budget (AWPB -2014) - Annual Budget proposal to MoF.	- JAR and Report and agreed milestones for 2015 (aide memoire) - Annual Health Sector Performance Report 2013 published - Annual work plan and budget (AWPB -2015) - Annual Budget proposal to MoF.	- JAR and Report and agreed milestones for 2016 (aide memoire) - Annual Health Sector Performance Report 2014 published - Annual work plan and budget (AWPB -2016) - Annual Budget proposal to MoF. -	- JAR and Report and agreed milestones for 2017 (aide memoire) - Annual Health Sector Performance Report 2015 published - Annual work plan and budget (AWPB -2017) - Annual Budget proposal to MoF. - HSSP II (2017-2020) adopted by October 2016

	Indicator 1.2	**Timely availability of planning and budgetary documents**			
	Source of data	**DOH Annual Report**			
Objective 3: Effective governance, leadership and management and institutional capacity at all levels of MOH	- Central capacity partially exists but not Regional or District levels.	- Institutional review report. - Central MoH with fully implemented institutional plan and functional departments. - Strategic planning and technical assistance unit established and functioning at central level. - Regional authorities nominated. - 4 Regional offices functioning (according to established norms)	- 11 Regional offices functional. - 50% of districts in 4 Regions functional and working with RMOs	- 100% districts in 4 Regions and 15% all districts functional	- 100% districts in 4 Regions and 30% all districts functional
	Indicator 1.3	**Number of DOH Departments, ROs and Districts in line with institutional assessment**			
	Source of data	**Institutional assessment within Annual DoH report.**			
	- A draft leadership and management development programme is available. - MOUs in place for collaborating institutions.	- Leadership & management plan finalized and financial support in place. - MoU in place for L&M collaborating institutions - Year 1 L&M programme implemented	- Year 2 L&M programme implemented	- Year 3 L&M programme implemented	- Year 4 L&M programme implemented
	Indicator 1.4 (core)	**Number of senior managers trained in line with L&M programme.**			
	Source	**Annual L&M Progress Report**			

Objective 4: Build community governance arrangements at Regional, District and Facility levels. (Regional Health Committees, District Health Boards, Health Facility Committees)	- No Boards and some Committees exist including TORs	Mapping report on local governance structures. - 4 (Phase 1) Regions: - 4 Regional Health Committees and 20% DHBs in place with gender balanced membership.	Four regions: 4 Regional Health Committees 50% DHBs 25% HFCs established. Other regions: 7 Regional Committees 15% district health boards	Four regions: 4 RCs 60% DHBs 40% HFCs Other regions: 7 Regional Committees 25% DHBs 10% FHCs	Four regions: 4 RCs 75% DHBs 70% HFCs Other regions: 7 RCs 40% DHBs 20% HFCs
	Indicator 1.5	**Number and percentage of local committees established with membership norms**			
	Source of data	**Regional and annual DOH reports.**			
Objective 5: Establish framework for health sector coordination and partnership (at all administrative levels and including international development partners, INGOs, NGOs).	- Health sector coordination and meetings at Nairobi level, - Health cluster (OIC and WHO) coordination meeting in Mogadishu,	- Health sector coordination framework in place (includes JAR) - Key zonal meetings held at MOH Mogadishu. - Humanitarian cluster and health sector meetings coordinated. - Database of external development assistance (including humanitarian and development programmes). - Draft TA harmonization plan.	- Aid effectiveness report published - Annual update report of health sector database. - Annual Report on coordination and aid effectiveness. - TA Harmonisation plan signed by FG and partners. - Environmental health coordinating committee established	- Annual update report of health sector database. - Annual Report on coordination and aid effectiveness.	- Annual update report of health sector database. - Annual Report on coordination and aid effectiveness.
	Indicator 1.6	**Number of development partners providing timely data.**			
	Source	**Database review and verification exercise**			
Objective 6: Establish agreements (contracts/MoU) with Service Providers that are supporting health services (including standards and reporting requirements).	- No MOUs currently in place	- Mapping study report. - Agreements in place between MOH and Service Providers in 4 (Phase 1) Regions	- Agreements in place between MOH and Service Providers in all Regions	- Continue	- Continue

	Indicator 1.7	**Number of Service Providers with MOUs and under Contracting agreements.**			
	Source	**Annual DOH report.**			
Objective 7: Emergency preparedness and response capacity within the national system	- Cluster emergency preparedness in place - Somali Disaster Management Agency at Prime Minister's Office	- Somali Disaster Management Agency at PMO - Emergency preparedness unit with focal person in MOH in place to coordinate with health cluster and link to SODMA - Weekly coordination meeting between MOH and EHA Surveillance System notifications by MoH	- Unit fully functional by mid 2014. - Emergency preparedness Plan in place - Harmonised process for emergency funding led by MOH - Central Reference Laboratory established	- System fully operational	- Continue
	Indicator 1.8	**Percentage of humanitarian funds contracted with participation of DOH.**			
	Source	**DOH reports/ committee minutes**			

Strategy 2	**Human Resources for Health: Increase the health workforce, improve their skill balance and strengthen their capacity.**				
Objective 1: Develop human resources management policy and plan.	- No HR Policy or Plan in place. - HR assessment started	- HR Policy developed (including core definition of cadres and relationship to civil service commission) - Basic HRIS in place. - Workforce Master plan in place (including staffing norm for primary and secondary levels).	- Year 1 Workforce Masterplan implemented -	- Year 2 Workforce Masterplan implemented	- Year 3 Workforce Masterplan implemented
	Indicator 2.1 (Core)	Number and Proportion of Health Facilities meeting the EPHS staffing norm.			
	Source of data	Annual DOHHR report			
Objective 2: Establish revised standard remuneration levels and seek harmonization from all donor agencies and service providers	- Various levels of remuneration levels paid.	- Standard remuneration levels for all public sector health workers, agreed, published and circulated to donors and service providers together with accountability requirements	- Six monthly report on adherence to the standard - Organizations under contract or MoU following government remuneration standards	- Six monthly report on adherence to the standards.	- Six monthly report on adherence to the standards.
	Indicator 2.2 (Core)	Number of partners providing services adhering to DOH remuneration standards			
	Source of data	Annual MOH HR Report			
Objective 3: Revive and strengthen health professional associations	- Associations in existence but limited functioning.	- Business plans for Nurse and Midwife Association; Pharmacist Association; Medical Association	- Nurse and Midwife Association;Pharmacist Association; Medical Association functioning.	- National Association validating health professionals	- Continue validation process
	Indicator 2.3	Number of health professionals registered with professional associations			

	Source of data	Professional association database reports.			
Objective 4: Training and capacity building for human resources to provide services in line with EPHS	- Partial training capacity provided by local academic institutions do exist but not standardized. - No paramedic training centre.	- Standardized curricula. - Pre- and In-service training Plans for all core cadres. - Pre- and In service training plans implemented	- Pre- and In service training plans implemented - Paramedic training centre functional	- Pre- and In service training plans implemented	- Pre- and In service training plans implemented
	Indicator 2.4	Number of staff by cadre completing pre- and in-service training			
	Source of data	Annual DOH HR Report			

Strategy 3	**Service Delivery: Roll out the provision of equitable health services and functional health facilities in all regions**				
Objective 1: Basic EPHS health and nutrition services (at least three core EPHS programmes*), available in all regions by December 2016 **(* Maternal, reproductive and neonatal health; nutrition services, Child health; Communicable disease surveillance and control, including WASH promotion)**	- Little reliable data currently available on services, service utilization and financing. - HMIS partial data only.	- Masterplan for health services across all regions completed (including primary and secondary care, laboratory and blood services)	- 10% of health facilities providing services in line with EPHS guidelines (3 core programmes).	- 20% of health facilities providing services in line with EPHS guidelines.	- 30% of health facilities providing services in line with EPHS guidelines.
	Indicator 3.1 3.1(a) 3.1(b)	Number and Percentage of facilities providing basic package of EPHS services; % deliveries attended by an SBA % of children under one year of age receiving DPT3;			

Objective 2: EPHS (6 core programmes) available in selected districts within accessible regions	- Pilot 4 Regions and Districts identified.	- 10% of assessed HFs in pilot areas providing (6 programme) EPHS services by end 2013	- 25% of HFs in pilot areas providing (6 programme) EPHS services by end 2014 in pilot areas.	- 35% of HFs pilot areas providing (6 programme) EPHS services by end 2015	- 50% of HFs pilot areas providing (6 programme) EPHS services by end 2016
	Indicator 3.2 (Core) Indicator 3.2 (a) (Core) Indicator 3.2 (b) (Core) Indicator 3.2 (c) Indicator 3.2 (d) Indicator 3.2 (e) Indicator 3.2 (f) Indicator 3.2 (g)	Number and Percentage of facilities implementing the 6 core programmes of the EPHS; See 3.1(a) – (f) % clients satisfied with services (composite indicator) % of facilities providing quality services (composite indicator) % of pregnant women attending at least three ANC visits Percentage of infants exclusively breast fed for 0-5 months % children under 5 sleeping under a LLITN Number of people who received testing and counseling services and have received their test result. TB treatment success rate			
	Source of data	HMIS, Annual Household survey and Annual Facility Survey			
Objective 3: Strengthened and harmonised community servic capacity	- ICCM, CHW and FCHW initiatives - Little support for nomadic groups	- Harmonised Community health care strategy in place.	- 20% Districts with CHW initiative in the 4 pilot regions and districts	- 35% Districts with CHW initiative in 4 pilot regions and districts	- 50% Districts with CHW initiative in 4 pilot regions and districts
	Indicator 3.3 (core)	Number of community based health workers (by region and urban/rural)			
	Source of data	HMIS/ Annual DOH Report			
Objective 4: Develop national and regional referral capacity for obstetric and surgical emergencies and trauma (including blood banks and 4 additional EPHS programmes)	- National hospital has limited capacity at present, including very basic blood bank only. - Plan in place for Banadir, Galgudud Lower Shabelle and Gedo hospitals (CEOC).	- Secondary care assessment report. - Hospital development plans in place.	- National Hospital (Banadir) and 4 regional hospitals rehabilitated, equipped and staff trained.	- Banadir Hospital functioning as national referral hospital. - 4 Regional hospitals functioning as referral hospitals.	
	Indicator 3.4 (a) Indicator 3.4 (b)	Number of obstetric emergency referrals from districts to referral hospitals (disaggregated by level) Number of patients under mental health treatment and/or counseling (disaggregated)			
	Source of data	HMIS			

Strategy 4	**Health Financing: Develop health financing system which relies more on national financing and community based resources, that allocates budget to priorities, accounts for spending accurately and uses national and international funds more efficiently.**				
Objective 1: Increase the proportion of the national budget spent on health to 7% by the end of the Plan.	- 2011: 0.6% of National Budget ($600,000) - Actual 2011 funding $228,000	- 4% of National budget allocated for health sector. - Annual health sector budget proposal submitted on time	- 5% of National budget allocated for health sector. - Annual health sector budget proposal submitted on time	- 6% of National budget allocated for health sector. - Annual health sector budget proposal submitted on time	- 7% of National budget allocated for health sector. - Annual health sector budget proposal submitted on time
	Indicator4.1 (Core) Indicator 4.2 Indicator 4.3	Percentage of National Budget allocated to the health sector Proportion of total health budget from government budget Percentage expenditure of national budget			
	Source of data	MOF Budget Statement DoH Annual Financial Accounts			
Objective 2: Establish (national) health accounts detailing all sources of health sector financing including from national budget, community/diaspora sources, external assistance and out-of-pocket expenditure.	- No consolidated data at present	- NHA guideline produced. - Preparatory report of National Health Accounts data.	- National Health Accounts (2013) published.	- National Health Accounts (2014) published.	- National Health Accounts (2015) published.
	Indicator 4.4 (Core)	Total expenditure on public health sector, disaggregated by source			
	Source of data	NHA report			
Objective 3: Create a health financing framework to ensure adequate and predictable funding of the sector	No framework in place.	- Health financing options paper. - Draft Health financing strategy produced by MOH. - Draft Joint financing agreement	- Health Financing Strategy adopted by FG - JFA signed by FG and on-budget partners. - Guideline on community support to health services.	- Health Financing review report to JAR	- Health Financing review report to JAR
	Indicator 4.5	Number of development partners signing JFA			

	Source of data	JFA document			
Objective 4: Sound financial management and accounting system for MOH	No FMS in place	- Timely Quarterly and Annual Financial Report of Health Directorate	- Published accounts. - Pre-Audit assessment	- Financial accounts. - Annual Audit report	- Financial accounts - Annual Audit report.
	Indicator 4.6	Timely expenditure reports and audit sign-off			
	Source of data	JAR report; Annual DOH Financial Report			

Strategy 5	**Medical Products and Technologies: Ensure provision of appropriate and sufficient medical products and technologies.**				
Objective 1: Quality of drugs and medical supplies to health facilities meet international standards for safety and efficacy	No drug registration or quality control systems. Essential drugs list, primary health care guidelines and standard treatment guidelines in place. Plan to introduce minilab and rehabilitate facilities for one site (people nominated)	- Updated essential drugs list and standard treatment guidelines. - Medicines Steering committee. - [see above - Drug legislation and policy] - Introduce basic quality control system. - Development Plan for Drug Regulatory Authority.	- Drug verification system at the pharmacy level in place. - Drug regulatory authority established	- Drug registration and enforcement system in place.	- Drug registration and enforcement system in place.
	Indicator 5.1 (Core)	% of substandard drugs identified as a proportion of all tests undertaken at minilabs			
	Source of data	Minilab reports.			
Objective 2: Promote rational use and management of drugs and medical supplies	MOH guidelines on rational drug use in PHC in place	- Training rational use of drugs public and training institutions - Distribution of updated standard guidelines - Supervisory system	- Expand to retailers and enforce	- Expand to retailers and enforce	- Expand to retailers and enforce

		based on selected tracer conditions			
	Indicator 5.2	Number of health providers trained in rationale use of drugs.			
	Source of data	Training reports			
Objective 3: Improve health facilities physical infrastructure, equipment and supplies	- No central store or regional stores place	- Undertake Infrastructure assessment for Central and pilot Regions and Districts. - Infrastructure development plan.	- Reconstruction and equip MOH central medical store including cold chain - Three regional medical Stores.	- Infrastructure developmer plan implemented	- Infrastructure developmer plan implemented
	Indicator 5.3 (a) Indicator 5.3 (b) (Core)	Number of new and rehabilitated facilities by region and type % of health facilities with no stock-outs of selected drugs and supplies in all 4 quarters			
	Source of data	Annual Health Facility Survey Report, HMIS, Supervision reports			
Objective 4: Introduce new (environmentally appropriate) technologies (solar, water catchment, waste management) in line with service delivery roll-out.	- Limited use of new technologies for basic services.	- New technologies in 25% of functioning health facilities in pilot regions	- New technologies in 35% functioning health facilitie pilot regions	- New technologies in 45% functioning health facilities in pilot regions b	- New technologies in 50% functioning health facilitie regions
	Indicator 5.4	Number and percentage of health facilities with renewable technology installations			
	Source of data	Annual Health Facility Survey Report			

Strategy 6	**Information and Research: Establish a comprehensive monitoring and evaluation system and research capacity.**				
Objective 1: Further develop design and harmonize the HMIS system	Limited system in place. HMIS Unit established	Assessment report. Design of upgraded HMIS system and tools. Data Use Plan	50% of pilot district public facilities included in HMIS.	100% of pilot district public facilities and 30% private providers included in HMIS. 30% of all public health facilities in HMIS.	100% of pilot district facilities and 30% private providers included in HMIS. 30% of all public health facilities in HMIS.
	Indicator 6.1 (a) (Core) Indicator 6.1 (b) (Core)	Number of health facilities providing timely and complete HMIS reports % of HSSP results framework indicators reported in the DOH annual report			
	Source of data	HMIS reports			
Objective 2: Establish research capacity and health survey and research priorities identified.	- Several surveys exist without coordination and sharing of information with MOH - MICs not done. - No DHS/No MICS	- HSSP baseline completed. - Synthesis report on all studies and surveys in SCS. - Research Plan published.	• Facility and Household survey reports. • KAP (WASH) Survey report.	- Facility and Household and KAP survey reports.	- Facility and Household and KAP survey reports.
	Indicator 6.2	Annual survey reports available on time			
	Source of data	MOH Reports			
Objective 3: Establish integrated diseases surveillance system.	- None at MOH level - Disease notification system in place but not integrated. - Plan to build Central Reference Laboratory in Mogadishu.	- Disease notification information shared by WHO with MOH. - Declaration of outbreaks by MOH. - Weekly surveillance reports. - Central laboratory development plan prepared	- Weekly surveillance reports	- Monthly surveillance report. - Central Reference Laboratory completed.	Monthly surveillance reports
	Indicator 6.3	Number of DOH surveillance reports produced on time			
	Source of data	Surveillance reports			

13. IMPLEMENTATION, MANAGEMENT AND REPORTING

Existing arrangements for implementing and managing the health sector in South Central Somalia are organized around a number of meetings of UN agencies, donors and zonal health authorities in committees, boards, forums, working groups and clusters. These bodies have developed over time with unclear, overlapping and sometimes inappropriate responsibilities.

Most of the meetings where the management of the health sector currently occurs are based in Nairobi or in agencies' headquarter or regional offices. This isolates the DOH from decisions, and places an enormous travel and time burden on key DOH officials who are required to travel to Nairobi to participate in meetings.

Although there are UN agency representatives in South Central Somalia, they appear to operate somewhat independently from their HQs.

There is limited involvement of the DOH in the allocation of external resources to the sector. This is especially true of those of the Health and Nutrition Clusters of the UN Office for the Coordination of Humanitarian Affairs that account for a good deal of spending of health in South Central Somalia.

Overall, current implementation, management and reporting arrangements result in decision-making without government, scant preparation of meetings, poor recording of decisions and inadequate follow up. As the country builds its capacity and the transition from humanitarian to development work progresses, these arrangements do not support the establishment of a more efficient and effective health system. The HSSP is a good opportunity to improve these arrangements.

During the HSSP period, it is planned that external support will increasingly move from emergency and humanitarian assistance to development support. A key aspect of this will be better coordination and effective use of resources available to the health sector. Establishing new implementation, management and reporting arrangements *carefully and quickly* will be crucial to progress in implementing the Plan.

There are four main responsibilities involved in achieving the objectives of the HSSP:

- Day to day planning and implementation of activities designed to achieve the results of the plan.
- Harmonizing various partners' contributions to implementing the plan.
- Financing the plan.
- Monitoring implementation of the plan and evaluating its achievements.

Day-to-day planning and implementation of the activities

The DOH should be gradually empowered to assume increasing leadership of the health sector, working with support from and in collaboration with public and private sector stakeholders, including development partners, to implement the HSSP over the next four years. In itself, the HSSP is an important step in establishing this role with its clear framework and timeline for developing systems and providing health services across the regions.

In order to carry out this function, the DOH will form a Policy and Strategy Unit, led by the Director General, with all Departmental Directors participating actively as members. The Unit will lead on planning activities, coordinate all inputs to the HSSP and ensure that results are achieved. The Unit will report to the Minister. It will be provided with a team of senior-level experts to support its work, recruited through international competition from the private sector, located in the DOH and working alongside the Unit. The current Health Systems Analysis Team (HSAT) will be incorporated into this Unit. There will be no need for the HSAT to be in Nairobi.

Given the current capacity of the DOH to manage the implementation of the HSSP, a great deal of contracting out of services (health systems development, health services provision, procurement and logistics and so forth) will be required. A key function of the Policy and Strategy Unit will be to award contracts for delivering many of the activities of the HSSP. Currently, donors, UN agencies and Clusters of the UN Office for the Coordination of Humanitarian Affairs award their own contracts for all of these tasks with little or no coordination among themselves or consultation with the DOH. Different contracting arrangements are used, involving different levels of costs and standards. Contracting procedures can be very lengthy. This situation cannot continue if the HSSP is to be implemented successfully and value for money increased.[xxi] A contracting policy and new contracting arrangements will need to be discussed, developed and put in place, probably involving the appointment of a specialised management group to work alongside the DOH to provide technical and implementation support to develop its capacity to assume the contracting function in the long term.[xxii] A long-term transition plan will be required to replace the various uncoordinated and inefficient contracting systems with a more unified procedure that improves efficiency and value for money.

A second key function of the Policy and Strategy Unit will be to develop an Annual Work Plan and Budget for the implementation of the HSSP. This will be based on the HSSP and its costs, but involve a "bottom up" exercise beginning with annual planning at regional level, especially for strategy 3, done in October-November each year and presented to a Health Sector Strategic Plan Financier Group (HSSPFG, see below) in November for consideration and support.

Harmonizing partners' contributions to the HSSP

A Health Sector Coordination Group (HSCG) will be the key coordination mechanism for the health sector. *Coordination means harmonizing technical strategies and programme*

approaches, avoiding duplication of activities, preventing geographic imbalances in resource allocations, avoiding conflicting activities and flagrant inefficiencies to improve value for money. Meeting on a quarterly basis in Mogadishu, and chaired by the Director General, this Group will include the main public and private stakeholders in the sector, plus representatives of development partners. It should include representatives from other key government departments too. The Group will also have representation from Regional Health Teams so that local conditions and needs can be reflected in coordinated planning. The Group may decide to established short term Technical Working Groups primarily to address new or difficult technical issues where this is not already clear evidence for programme design. The Director of Planning will chair these technical working groups.

It is essential that the work of the Health Sector Coordination Group be communicated to senior representatives of those agencies that participate, so that Nairobi level meetings do not duplicate, "second guess", contradict or simply fail to take notice of the decisions and outcomes of the Zonal level.

Financing the implementation of the HSSP

Although the HSSP envisages a bigger share of the national budget being earmarked for the health sector, a realistic assessment is that external support will remain the main source of financing for the public health sector for the foreseeable future. The main sources of financing are likely to be the bilateral donors, the UN agencies, the GFATM and GAVI. The HSSP is a guide to these financiers to allocate their funds in support of specific strategies in their entirety, or to stated objectives to achieve specific results.

A Health Sector Strategic Plan Financier Group (HSSPFG) will be formed of *senior* representatives of all agencies, including the UN Office for the Coordination of Humanitarian Affairs, investing more than $5m annually in the HSSP, plus the three Ministers of Health and Ministers of Planning. Representatives of major financiers must be individuals who are able to make funding commitments. It will meet in Nairobi twice a year. In June it will agree which agencies will represent financiers on the DOH-donor Joint Annual Reviews (JAR) that will take place in each July. In November it will receive and approve a mid-year programme and financial progress report resulting from the JAR, as well as decide funding of the sector the next year, based partly on the DOH's last Annual Report against the Strategic Plan Results Framework.

Coordinating the implementation of activities designed to achieve the results of the HSSP

A new Health Sector Committee will focus on ***technical*** *issues,* ***not*** *financing*. It will comprise representatives of agencies that are providing advice on the design of health programmes, rather than their funding. The Health and Nutrition Clusters operating under the UN Office for the

Coordination of Humanitarian Affairs should be included on this Committee. The main task of the Committee is coordination – harmonizing programmes that are being supported by all actors, avoiding duplication, preventing geographic imbalances in inputs, avoiding conflicting activities and flagrant inefficiencies. The other work of this committee will be to plan in detail the JAR of the health sector. Finally, it will provide technical guidance to the DOH – for example sharing new global approaches to health issues or new learning from programme experience. ***The Health Sector Committee will not make any funding decisions.*** It will meet every 4 months, in Nairobi.

This structure replaces all existing Committees that are currently involved in the health sector and a consensus on these new arrangements needs to be facilitated. Terms of Reference and membership for each of the four key committees will need to be written.

Monitoring implementation of the plan and reporting its progress.

Four primary tools will be used to report on the progress of the HSSP and therefore on the sector as a whole to the Health Sector Strategic Plan Financier Group and to the Health Sector Committee

- The HMIS
- An Annual Report from the DOH and from each Region
- A Joint Annual Review (JAR) of the sector
- An annual Facility Survey

A consolidated list of the indicators that will be measured by these tools is at Annex 3.

Overall *impact* in the health sector will be measured using six key indicators: the maternal mortality ratio, the neonatal, infant and under 5 mortality rates, the contraceptive prevalence rate and the under 5 wasted rate. At present there is no baseline data available for these indicators in South Central Somalia. When baselines become available the DOH will set appropriate periodic targets and milestones.

The MOH and Regions' annual reports will provide information on progress of work on objectives of strategy 1 and 2. The databases of professional associations - when set up - will generate an annual report on the progress of registering public health workers.

The HMIS will be the primary tool for monitoring progress on achieving the objectives of strategy 3. The HMIS will enable the MOH to measure trends in *outputs*; primarily service use. As the EPHS rolls out, and the quality of services increases, increases in the number of people using public health services should be detected. Coverage of key interventions such as immunization might also be calculated where population data is available. The HMIS will also provide some information on services provided by private sector providers. If plans to integrate human resource information into the HMIS are successful, this will also allow strategy 2 to be monitored. The annual facility survey will supplement

HMIS service data and provide some explanation of observed trends.

Strategy 4 will be monitored by examination of the National Budget statement and the allocation to the DOH, and in 2015 and 2016, the publication of some initial Zonal Health Accounts.

Progress in achieving the objectives of Strategy 5 will be tracked by reports from the regional mini-labs, the Annual Facility Surveys and training results.

The HMIS and the DOH's Annual Report will provide data to monitor strategy 6 objectives.

Progress on achieving better coordination and value for money from investments in the health sector will emerge from the Joint Annual Review exercise. The design of the review requires detailed work, but it will involve three or four teams comprising senior DOH officers and representatives of key development partners and financiers working together in undertaking a strategic review of progress in implementing the HSSP. The teams will consult with Regional Health Teams and make visits to facilities in those regions that are secure to collect information and exchange views in a "plenary" meeting. The results of the JAR will feed into the annual work-plan exercise. The JAR will encourage partnership and transparency.

Consolidated Somalia Annual Health report:

The use of a common set of core indicators across all three HSSPs will enable a consolidated country-wide report on progress to be drafted on an annual basis drawing on the zonal reports and JAR meetings. An overview JAR meeting after zonal reviews is also envisaged to share lessons and provide a wider picture of progress

14. COSTING AND FINANCING

Estimated financing requirements for implementing the HSSP by strategic area are presented below table 4. Total financing requirement is **$101** million over four years, or approximately **$25** million per year.

Actual total financing will be influenced by the performance of the economy at macro level, including unpredictable inflation, exchange rate fluctuations, increased population and health service demand due to security improvement in South Somalia regions. Other important variables that will impact upon the total costs are population growth and migration dynamics, changes to the disease burden, the success or otherwise of integrating the current vertical programmes into the EPHS. These variables will have to be assessed regularly when annual work plans and budgets are being developed.

Table 4: HSSP Implementation Costs Estimates

Strategies	2013	2014	2015	2016	Total
Governance and Leadership	1,652,203	1,193,849	802,773	664,779	**4,313,605**
Human Resources	895,000	2,351,000	180,000	234,000	**3,660,000**
Health Services	19,058,758	25,854,427	20,815,533	22,195,357	**87,924,075**
Health Financing	824,750	333,000	187,000	151,000	**1,495,750**
Medicines and Consumables	545,680	222,590	236,395	102,590	**1,107,255**
Health Management Information System	919,517	639,817	711,525	272,825	**2,543,684**
Total	**23,895,908**	**30,594,683**	**22,933,226**	**23,620,552**	**101,044,370**

COSTING ASSUMPTIONS

General Approach

Due to the unique political and geographical characteristics and large population movements (nomads, refugees, IDPs) in Somalia, actual residential population estimates for the three zones vary considerably. Hence, the costing modules in the OneHealth tool that rely on target populations (i.e. "population needs") and population ratios to estimate costs for providing health services cannot be used to produce reliable cost estimates for the HSSP. The cost estimates here are developed using capacity projections and ratios. For instance, instead of the doctor or nurse per 1,000 population, future human resources needs, and therefore their costs, were estimated based on the health facility targets per level of the EPHS per region and agreed and feasible staffing norms by facility.

Therefore Activity Based Budgeting (ABB) was used as a general approach in costing the HSSP. The adjusted Essential Package of Health Services costing tool (for the health services building block) and the "OneHealth" tool were utilised in combination to produce the actual HSSP cost projections.[xxiii][xxiv]

Costs estimated for the implementation of the HSSP are *additional* and *complementary* to existing expenditures on current health programmes, especially vertical programmes. More specifically, the vertical programmes *not included in these cost estimates* are polio, EPI, malaria, TB and HIV/AIDS, beyond the components that are planned to be the part of the EPHS. The costs for services currently provided under these vertical programmes would eventually be fully substituted by the HSSP costs as vertical programmes are integrated into EPHS as envisioned by the HSSP. On the other hand, current investments in health systems improvements, such as

those by the GFATM in the HMIS, are encompassed in the costs of the HSSP.

Most capital costs, including those required for the construction and equipment of health facilities, regional warehouses and the pharmaceutical logistical system were budgeted under the EPHS expansion, or Health Services Strategic Area. [xxv] The estimated costs for the HSSP were divided into capital and recurrent costs. A phased approach in both geographical expansion of the EPHS and introduction of all programmes of the EPHS was adopted to allocate capital and recurrent cost and human resources requirements from year 2013 to 2016.

The HSSP costing tools and modified EPHS costing tools produced for each zone were adjusted and the HSSP costs recalculated to reflect the current security improvement and increased population in South Somalia. For example, pharmaceutical consumption, human resources needs, and training costs will likely change as the Plan is implemented, requiring cost re-estimates each year during work-plan/budget development.

Data Limitations

In the case of Somalia, critical sets of data that are normally used to calculate the health sector financial envelope are still missing. For instance, reliable macroeconomic projections and data on private health consumption and expenditures are not available. Data on actual consumption of pharmaceuticals and medical consumables by facility and district levels is also lacking, even for regions where the EPHS is being piloted.

The Essential Package of Health Services

In estimating the costs of implementing the HSSP, most of the assumptions used in the EPHS costing tool were maintained. [xxvi] However, several notable changes were introduced to produce cost projections for the EPHS expansion planned under the HSSP, namely:

- *Salary scales*: The salary scale used was based on the new salary remuneration packages recommended, but not yet adopted.

Table 5: Recommended New Salary remuneration packages for selected categories of health providers:

Grade	Category examples (not exhaustive)	Alternative Salary Rate (ASR)
Grade A		
A1	MoH Senior Director	1,500
A2	Departmental Director, Central MoH	1,200
A3	Regional Medical Officer, Regional Health System CEO	1,000
A4	Regional/ National Hospital Chief Medical Officer	1,000
A5	District Hospital CMO, District Hospital CEO	1,000
A6	Referral Health Centre CMO/CEO	1,000
A7	Senior Specialist Doctor (Department Head)	1,200
A8	General Doctor, Specialist Doctor	800
A9	HMIS/Transport/RMS Manager (Region/RHC) - university qualified	700
Grade B		0
B6	Health/Clinical Officer, RHC/ DH Administrator, Hospital Chief Nurse	550
B7	Registered Midwife with (surgical diploma)	550
B8	Management-level Nurse, Management-level Pharmacist	500
B9	HMIS/Transport/RMS Manager (Region/RHC) - secondary education	450
B10	Registered Nurse/Midwife/Pharmacist, Lab Technician	450
Grade C		0
C7	HMIS Officer	300
C8	Community Midwife, Pharm/Lab/X-ray Assistant	300
C9	Auxiliary Nurse	250
C10	Community Health Worker (CHW)	250
C11	Senior Maintenance Tech, Senior Driver (RHC, Hospital)	200
Grade D		0
D12	Maintenance Tech, Driver, Senior Health Aide	150
D13	Health Aide	120
D14	Senior Cleaner, Senior Security	110
D15	Cleaner, Security	100

- *Projected cost of pharmaceuticals and medical supplies* for Primary Health Unit (PHU), Health Centre (HC) and Referral Health Centre (RHC) were revised based on the UNICEF/Somalia data on the updated unit costs and facility level utilisation for repacked Primary Health Unit Kits, Maternal and Child Health Care Centre (Health Centre) Kits (HCK), Midwifery Kits (MK). [xxvii] The original projections from the EPHS costing tool for pharmaceuticals and medical supplies were also maintained in the adjusted EPHS costing tool for comparative purposes.

Table 6: Revised cost and consumption projections for pharmaceuticals and medical supplies

	Unit Cost	With Freight & Logistics	Primary Heath Unit			Health Centre			Referral Health Centre		
			Consumption			Consumption			Consumption		
			Low	Medium	High	Low	Medium	High	Low	Medium	High
PHU Kit (5000 pop. X 3 months)	900	1,170	2	4	6						
HC Kit (10,000 pop. X 3 months)	2,000	2,600				2	4	6	5	10	30
Midwifery Kit (100 deliveries)	1,200	1,560					1	2	2	4	6
Surgical/Obstetric Kit for C-Section	5,000	6,500								1	2
Total UNICEF supplied			*2,340*	*4,680*	*7,020*	*5,200*	*11,960*	*18,720*	*16,120*	*38,740*	*100,360*
Additional Drugs and Medical Consumables ($ per year)			3,000	3,600	4,200	9,600	14,400	16,800	18,000	21,600	28,800
Total Estimated Annual Consumption ($)			**5,340**	**8,280**	**11,220**	**14,800**	**26,360**	**35,520**	**34,120**	**60,340**	**129,160**

- *Capital Costs* were updated based on average actual expenditures incurred by current EPHS pilots and UNCEF data on construction costs of maternity wards for upgraded Health Centres (HC). Rehabilitation costs were estimated from $50 (for a PHU) to $80 (for HCs, RHCs, and RHs) per sq. meter. Construction costs were projected within the range of $160 (for Regional Medical Store) to $225 for the Regional (Generic) Hospitals. Construction costs and specifications for maternity wards (total space and composition) were estimated based on UNICEF data. Based on updated specifications, maternity wards to be constructed consist of a labour room, a delivery room, a post delivery room, two attached toilets, a placenta pit, a septic tank and an overhead water tank with an estimated cost of $50,000 without solar power, the cost of which is estimated at $9,000. The following assumptions are made:

  - All RHs and RHCs will be renovated, at $80 per sq. meter for in average of 1200 sq. meters for RH and 800 sq. meters for RHC;
  - Construction of new maternity wards for up to 70% of the HC to be established/upgraded;
  - Rehabilitation or construction of Regional Medical Stores depending on the availability of existing suitable buildings within the zone;
  - Minimal rehabilitation for PHUs;
  - All newly established PHUs, HCs, RHCs and RHs to be equipped with standard full package of equipment defined in the EPHS tool.

The construction and equipment cost for the central DOH office was estimated at $2.1 million based on the construction estimate prepared by Engineer Mohamed Ahmed Fiqi (MOH construction advisor).

- *Staffing norms* for facilities (HCs and RHCs) phase two (years 2015-2016) were revised downwards considering human resources capacity constraints and limited production capabilities for specialized medical personnel, such as midwifes with a surgical diploma, dental and optical technicians, etc.

- *Costs of pre-service and in-service training* were estimated based on the revised staffing norms for health facilities and defined quantitative targets for facilities by level of care for each phase. The cost of in-service training was added to the facility level cost at 10% of the salary cost. This estimate is in par with the actual in-service training expenditure levels incurred by the EPHS pilots. Unit costs for pre-service training for each key type of health personnel to be trained were defined both by the existing curricula for medical doctors, registered nurses, midwifes, laboratory/pharmaceutical technicians and assistants, etc., as well as considering proposed future curricula (number of years to be trained) for other medical personnel not currently employed in the health system, such as clinical officers, midwifes and nurses with surgical diploma, anaesthetic assistants and qualified community health workers. Both the training costs incurred by the EPHS pilot implementers and tuition fees charged for teaching specific clinical and para- clinical specialities by the teaching institutions in the region were considered. When determining the training needs, the existing numbers of medical personnel by category, were also taken into account. However, the data on exact number of medical personnel available and employed in the public sector is generally deficient.

- *Implementation oversight and technical support* costs at 7% of total EPHS recurrent costs were added for implementing partners (companies, INGOs, NGOs) that will be assisting the MOH in expanding the EPHS.

Other Strategic Areas

- A separate more detailed costing of Strategy 1, Leadership and Governance, was undertaken. Costs for implementing the other strategic areas in the HSSP (Health Financing, Human Resources and Medicines and Consumables and Health Information) were estimated using the modules from the One Health tool. Final cost estimates are summarised in separate tables for each strategic area below.

- Unit costs (daily fee rates and travel and per diem expenses) associated with technical assistance (TA) were estimated using aggregated rates of $1,200 and $300 per day for international and national TA respectively.

- Unit Costs for a Household survey for South Somalia are based on Sh. 15,700 per person for 40 days' work whereas the cost of the Facility Survey was outsourced to national TA for $300 per day.

Costs per strategic area and objective

Table 7: Summary Cost for Governance, Leadership and Management

Governance, Leadership and Management Summary					Total
Objectives:	**2013**	**2014**	**2015**	**2016**	
Objective 1: Establish a policy and legal framework for the health sector	539,474	529,474	293,224	293,224	1,655,395
Objective 2: Establish effective planning and budgetary framework and processes.	523,419	346,839	331,839	150,919	1,353,017
Objective 3: Effective governance, leadership and management and institutional capacity at all levels of MOH	243,386	122,286	122,286	101,886	589,845
Objective 4: Build community governance arrangements at Regional, District and Facility levels. (Regional Health Committees, District Health Boards, Health Facility Committees)	136,000	52,250	-	78,750	267,000
Objective 5: Establish framework for health sector coordination and partnership (at all administrative levels and including international development partners, INGOs, NGOs).	103,000	83,000	20,000	20,000	226,000
Objective 6: Establish agreements (contracts/MoU) with service providers that are supporting health services (including standards and reporting requirements)	71,500	40,000	-	-	111,500
Objective 7: Emergency preparedness and response capacity within the national system	35,424	20,000	35,424	20,000	110,848
Total	**1,652,203**	**1,193,849**	**802,773**	**664,779**	**4,313,605**

Table 8: Summary Cost for Human resource

Human Resources Summary					
Objectives	**2013**	**2014**	**2015**	**2016**	**Total**
Objective 1: Develop human resource management policy and plan	228,000	228,000	-	-	**456,000**
Objective 2: Establish revised standard remuneration levels and seek harmonizations from all donor agencies and service providers	28,000	14,000	24,000	18,000	**84,000**
Objective 3: Revive and strengthen health professional associations	192,000	36,000	36,000	156,000	**420,000**
Objective 4: Training and capacity building for human resource to provide services in line with EPHS	447,000	2,073,000	120,000	60,000	**2,700,000**
Total	**895,000**	**2,351,000**	**180,000**	**234,000**	**3,660,000**

Table 9: Summary Cost for Health Services

Health Services					
Objectives	**2013**	**2014**	**2015**	**2016**	**total**
Objective 1: Basic EPHS (at least three core EPHS programmes*) avilable in all regions. (Maternal, reproductive and neonatal health; Child health; Communicable diseases surveillance and control, including WASH promotion)	492,000	120,000	96,000	72,000	**780,000**
Objective 2: EPHS (6 core programmes) in selected districts within accessible regions	15,095,758	24,634,427	20,619,533	22,023,357	**82,373,075**
Objective 3: Strenghened and harmonized community service delivery capacity	206,000	50,000	50,000	50,000	**356,000**
Objective 4: Develop national and regional referral capacity for obstetric and surgical emergencies and trauma	3,265,000	1,050,000	50,000	50,000	**4,415,000**
Total	**19,058,758**	**25,854,427**	**20,815,533**	**22,195,357**	**87,924,075**

Table 10: Summary Cost for Health Financing

Health Financing Summary					
Objectives					
	2013	**2014**	**2015**	**2016**	**Total**
Objective 1: Increase the proportion of the national budget spent on health to 4% by the end of the Plan.	72,000	72,000	18,000	18,000	180,000
Objective 2: Establish national health accounts detailing all sources of health sector financing including from national budget, community/diaspora sources,external assistance and out of pocket expenditre	36,000	144,000	52,000	16,000	248,000
Objective 3:To create a health financing framework to ensure adequate and predictable funding of the sector	221,750	-	-	-	221,750
Objective 4: Sound financial management and accounting system for MOH	495,000	117,000	117,000	117,000	846,000
Total	**824,750**	**333,000**	**187,000**	**151,000**	**1,495,750**

Table 11: Summary Cost for Medical Product and Technologies

Medical Product and Technologies					
Objectives	**2013**	**2014**	**2015**	**2016**	**Total**
Objective 1: Quality of drugs and medical supplies to health facilities meet international standards for safety and efficacy	389,285	120,000	120,000	-	**629,285**
Objective 2: Promote rational use and management of drugs and medical supplies	116,395	102,590	116,395	102,590	**437,970**
Objective 3: Improve health facilities physical infrustructure, equipment and supplies.	20,000	-	-	-	**20,000**
Objective 4: Introduce new (environmentally appropriate) technologies (Solar, water catchment, waste management) in line with service delivery roll-out	20,000	-	-	-	**20,000**
Total	**545,680**	**222,590**	**236,395**	**102,590**	**1,107,255**

Table 12: Summary Cost for HMIS

HMIS Summary					
Objectives	**2013**	**2014**	**2015**	**2016**	**Total**
Objective 1: Further develop design and harmonize the HMIS system	201,052	21,052	29,060	29,060	**280,224**
Objective 2: Esrablish research capacity and health survey and research priorities identified	320,965	33,765	284,965	33,765	**673,460**
Objective 3: Establish integrated diseases surveillance system	397,500	585,000	397,500	210,000	**1,590,000**
Total	**919,517**	**639,817**	**711,525**	**272,825**	**2,543,684**

15. RISKS AND ASSUMPTIONS

The final exercise in developing the HSSP was to assess the risks to the successful implementation of the plan. A list of risks was developed and each assessed for the likelihood of it occurring and the seriousness of its impact on the successful implementation of the plan. The "risk matrix" is presented in Annex 2. It is clear that the HSSP is a high-risk enterprise. This is to be expected, since the variables that can have a serious impact on the plan are largely outside of the control of the Directorate of Health. Where possible, mitigation actions have been designed and included in the HSSP to reduce the likelihood or impact of identified risks.

ANNEX 1 AN OVERVIEW OF THE ESSENTIAL PACKAGE OF HEALTH SERVICES - The EPHS

By far the most important element of this HSSP is the implementation of basic health services to the whole population. The Essential Package of Health Services model, or the EPHS, defines all these services, and the level of the health system that should provide them.

The EPHS was developed in 2009 and remains the prime mechanism for strategic service provision of the public sector health service n all three Zones. It helps to clarify health priorities and directs resource allocation. It also defines Directorate of Health responsibilities and activities at central and regional levels, particularly in coordination, management and supervision of services. It clarifies the role communities play in creating a sustainable and accountable health system. It aims to address current poor access to health and inequalities in health service provision. It provides a road map for action and is costed to enable detailed budgetary planning or advocacy purposes and for government, donors, municipalities, districts and communities to plan on how to increase their contributions.

The EPHS helps define health systems standards for the government, UN and NGO agencies and private service providers. It standardises and improves upon existing logistical and supply systems, and adopts essential drugs and equipment lists for each level of provision. While taking into account existing constraints, the EPHS acts as a blueprint for health sector development and future resource investments.

The EPHS consists of the following:

- four levels of service provision
- ten health programmes
- six management components

The essential package is implemented across four levels of service provision, each with a standardised service profile and each supported by a standardised set of management and support systems. The four levels of service provision are:

- Primary health unit (PHU)
- Health centre (HC)
- Referral health centre (RHC)
- Hospital (H)

Most management and supervision takes place at the regional level, as it is not envisaged that district capacity can be built up during the lifetime of the HSSP. The priority is on enabling the regional health system, and in future phases of health systems development a district management structure could then be created.

The six core programmes are:

- Communicable disease surveillance and control, including WATSAN promotion

- First aid and care of critically ill and injured
- Treatment of common illness
- HIV, STIs and TB

The four additional programmes are:

- Management of chronic disease and other diseases, care of the elderly and palliative care
- Mental health and mental disability
- Dental health
- Eye health

Medical specialities are included at hospital level.

Nutritional interventions are integrated across all programmes.

Each programme has promotional, preventive and curative aspects and includes activities for individuals, as well as at community and population levels.

Mental health should be streamlined across all levels of the health system. This is a desired aim, but there is currently not the financial or technical capacity to do this. A combined approach may be needed with all Community Health Workers (CHW) and nurses trained in psychosocial support skills, while psychiatrists and psychiatric nurses conduct outreach clinics in Referral Health Centres (RHC) and eventually health centres. This requires agencies to develop and champion mainstreaming of mental health care.

Finally, the EPHS includes six management and support components; specifically:

- Finance
- Human resource management and development
- EPHS coordination, development and supervision
- Community participation
- Health systems support components
- Health management information system

Three groups are involved in running the health system, each with its own set of specific management roles and responsibilities:

- Health facility staff (direct facility management)
- Regional health office (supervision and quality of care)
- Community health committee (oversight, ownership and support)

ANNEX 2: SOUTH CENTRAL SOMALIA HSSP RISK MATRIX

RISKS	PROBABILITY (high, medium, low)	IMPACT (high, medium, low)	ACTIONS TO ALLEVIATE	RESPONSIBILITY
A. POLITICAL				
1. Frequent change in political appointments	High	High	Strong institutional management syste	MOH Minister and DG
2. Political future structure of government (federalism)	Medium	High	Reconciliation, advocacy and awareness	MOH Minister and DG
3. Conflict continues in certain areas of the country	Medium	High	Peace building and negotiations / conflict resolution	MOH Minister and DG
B. **FINANCIAL**				
1. Accountability and corruption	High	High	Establish strong financial and auditing system/law enforcement	Law enforcement institutions / Ministry of finance
2. Dependence on foreign aid	High	High	Advocate for national resource and community participation	Government
3. Short of national and international budget	Medium	High	improve accountability and transparency / increase government contribution/ Advocacy	Parliament and ministry of finance
4. Unpredictability of international support	Medium	High	Aid effectiveness	Government
C. INSTITUTIONAL				

1. Unregulated and poor quality institutions	High	High	Regulations	Law enforcement / MOH
2. Key public institutions missing (Mainly legal and financial institutions)	High	High	Establish institutions (financial and legal)	government
D. TECHNICAL				
1. Shortage of professionals	High	High	Increase quantity and quality of professionals	MOH
2. Mal-distribution of available skilled personnel	High	High	Improve remuneration	MOH
3. Heredity vs. merit	High	High	Improve recruitment procedures based on merit	MOH
4. Poaching of senior staff by international organizations	High	High	Code of conduct; Uniform remuneration	MOH and Civil service commission , Development Partners

	Unacceptable under existing circumstance and requires immediate action to mitigate
	Manageable under risk control and mitigation actions.
	Acceptable risk, but requires constant monitoring

ANNEX 3: SUMMARY HSSP INDICATOR TABLE.

Results framework (monitoring and evaluation) – Indicators for HSSP

Number	Indicator	Source of data	Baseline	Target
A. Health and Nutrition Status				
A.1	Maternal Mortality Rate	TBC	Pending baseline	TBC upon baseline
A.2	Under-five motality rate	TBC	Pending baseline	TBC upon baseline
A.3	Infant Mortality Rate	TBC	Pending baseline	TBC upon baseline
A.4	Neonatal Mortality Rate	TBC	Pending baseline	TBC upon baseline
A.5	Contraceptive Prevalence Rate	TBC	Pending baseline	TBC upon baseline
A.6	Percentage of children under 5 –years of age, who are wasted	TBC	Pending baseline	TBC upon baseline

S1	**Leadership and governance: Leadership and governance: Strengthen the capacity of MOH to have more effective leadership and good governance in the health care delivery system in Somalia.**			
S1.1	Number of Legal Acts and Policies published as specified in HSSPs	DOH Annual Report	N/A	Acts and policies published by the end of 2013
S1.2	Timely availability of planning and budgetary documents	DOH Annual Report	N/A	Available by the end of 2013
S1.3	Number of DOH Departments, ROs and Districts in line with institutional assessment	Institutional assessment within Annual DoH report.	N/A	4 regions: End of 2016 15% districts
S1.4	Number of senior managers trained in line with L&M programme.	Annual L&M progress report	0	100% by the end of 2016
S1.5	Number and percentage of local committees established with membership norms	Regional and DOH Annual Report	0	2015 = 4 RHC, 60% DHB, 40%HFC
S1.6	Number of development partners providing timely data.	Database review and verification exercise	0	100% by the end of 2014
S1.7	Number of Service Providers with MOUs and under Contracting agreements.	Annual DOH Report	0	Ready and in use by the end of 2014
S1.8	Percentage of humanitarian funds contracted with participation of DOH.	DOH Report/ committee minutes	0	100% by the end of 2014

S2	**Human Resources for Health: Increase the health workforce, improve their skill balance and strengthen their capacity.**			
S2.1	Number and Proportion of Health Facilities meeting the EPHS staffing norm	Annual DOH HR Report	0	
S2.2	Number of partners providing services adhering to DOH standard remuneration package	Annual DOH HR Report	0	100%
S2.3	Number of health professionals registered with professional associations	Professional Associations database reports	0	100%
S2.4	Number of staff by cadre completing pre- and in-service training	Annual DOH HR Report	One post-basic midwifery school	100%
S3	**Service Delivery: Roll out the provision of equitable health services and functional health facilities in all regions**			
S3.1	Number and percentage of facilities providing basic package of EPHS services	Health Facility Survey; HMIS	0	2014= 10% 2015=20% 2016 =30%
S3.1(a)	Percentage of deliveries attended by a skilled birth attendant (SBA) (disaggregated by rural/urban)	HH; HMIS	Pending baseline	TBC upon baseline
S3.1(b)	Proportion of children under 1 year receiving DPT3 (disaggregated by rural/urban, sex)	HMIS; HH	Pending baseline	TBC upon baseline
S3.1(c)	Percentage of women of reproductive age (15-49) who know at least 3 pregnancy related danger signs	HH	Pending baseline	TBC upon baseline

S3.1(d)	Percentage people receiving WATSAN health promotion message in last 3 months	HH	Pending baseline	TBC upon baseline
3.2	Number and percentage of facilities implementing the 6 core programmes of the EPHS	HMIS	Pending baseline	TBC upon baseline
3.2(a)	Percentage of clients satisfied with health services (composite indicator)	Facility Survey	Pending baseline	TBC upon baseline
3.2(b)	Number of facilities providing quality services (composite indicator)	Facility Survey	Pending baseline	TBC upon baseline
3.2(c)	Percentage of pregnant women attending at least 3 ANC visits	HH; HMIS	Pending baseline	TBC upon baseline
3.2(d)	Percentage of infants, exclusively breast-fed for 0-5 months	HH	Pending baseline	TBC upon baseline
3.2(e)	Percentage of children under 5 years sleeping under a LLITN	HH	Pending baseline	TBC upon baseline
3.2(f)	Number of people who received testing and counselling services and have received their test results	HMIS; HIV programme reports	Pending baseline	TBC upon baseline
3.2(g)	TB treatment success rate	HMIS	Pending baseline	TBC upon baseline
S3.3	Number of community based health workers (by region and urban/rural)	Annual DOH Report; HMIS	Some exist in some regions	50% of districts of 4 pilot regions by the end of 2016
S3.4(a)	Number of obstetric emergency referrals from districts to referral hospitals (disaggregated by level)	HMIS	Exists in some regions but not	End of 2016, three regions and national (Banadir)

			consistent	referral hospitals functioning
S3.4(b)	Number of patients under mental health treatment and/or counselling (disaggregated)	HMIS	Some facilities are evolving in some areas but not functioning	Number of wards opened in the four regional and national (Banaadir) referral hospitals
S4	**Health Financing: Develop health financing system which relies more on national financing and community based resources, that allocates budget to priorities, accounts for spending accurately and uses national and international funds more efficiently.**			
S4.1	Percentage of National Budget allocated to the health sector	MOF /DOH Budget	0.6%	4% by the end of 2016
S4.2	Proportion of total health budget from government budget	MOF/DOH Budget	Pending baseline	TBC upon baseline
S4.3	Percentage expenditure of national budget	DOH Annual Financial Accounts	38% (2011)	100%
S4.4	Total expenditure on public health sector, disaggregated by source	NHA	Pending baseline	TBC upon baseline
S4.5	Number of development partners signing JFA	JFA document	0	TBC
S4.6	Timely expenditure reports and audit sign-off	JAR report; Annual DOH Financial Report	Pending baseline	TBC upon baseline
S5	**Medical Products and Technologies: Ensure provision of appropriate and sufficient medical products and technologies.**			
S5.1	Percentage of sub-standard drugs identified as a proportion of all tests	Mini-lab reports	Pending	TBC upon baseline

	undertaken at mini-labs		baseline	
S5.2	Number of health providers trained in the rationale use of drugs	Training reports	Pending baseline	TBC upon baseline
S5.3(a)	Number of new and rehabilitated facilities by region and type	Annual Health Facility Survey Report	Pending baseline	Four pilot regions would be rehabilitated by the end of 2016
S5.3(b)	Percentage of health facilities with no stock-outs of selected drugs and supplies in all four quarters	Facility survey/ HMIS/Supervision	Pending baseline	TBC upon baseline
S5.4	Number and percentage of health facilities with renewable technology installations	Annual Health Facility Survey Report	Limited number of renewable technology exist not known to what extent	TBC
S6	**Information and Research: Establish a comprehensive monitoring and evaluation system and research capacity.**			
S6.1(a)	Number of health facilities providing timely and complete HMIS reports	HMIS reports	0	TBC
S6.1(b)	Percentage of HSSP Results Framework indicators reported in DoH Annual Report	DoH Annual Report	0	All
S6.2	Annual survey reports available on time	MOH Annual Report	0	TBC
S6.3	Number of DOH surveillance reports produced of time	Surveillance Reports	0	TBC

ENDNOTES

iFood security and nutritional analysis unit, (FSNAU) July 2011
"A Decade of Aid to the Somali Health Sector, 2000 to 2009". Emmanuelle Capobianco and Veni Naidu. World Bank Working Paper 2011
[iii] Members of the Planning Task Force were: Dr Abdirizak Yussuf RH Co-ord, MoH; Dr Ahmed Jama Muse, Nutrition Coord, MoH; Dr Imran Ravji Head of H&N, UNICEF Hargeisa; Emilien Nkusi Health Sector Capacity Building Manager, THET; Ahmed Abdi Abdilahi, Administrator, MOH; Abdi Ahmed Nour, Director General, MOH; Khadar M Ahmed, Director of Planning, MOH; Jimaan Yussuf Mohamed, Dept Director, Manhal; Ahmed Deriye, M&E Advisor, Ministry of Planning; Abdi Hassan Dualleh, PHC Officer WHO; Una MacAskill, Consultant to MoH; Cliff Lenton, Consultant to MoH; Marina Madeo, Somalia Health Sector Coordinator; Rahma Sagadhi, Prog Officer-Coordination, MOH; Weli Da'ud Egal, Advisor Ministry of Planning; Ahmed Muhumad, Consultant to MoH; David Daniels consultant to the MOH, Kaki Zoidze, consultant to the MOH (different international consultants at various stages of the process.)
[iv] Agencies represented at the nutrition agency meeting, in addition to the MOH, were FAO/FSNAU, UNICEF, APP, DIAL Africa, ANPPCAN, SRCS, Save the Children Fund, CARE, the WFP and Merlin. UN agencies represented at the UN agency meeting were UNICEF, WHO, UNFPA, and the WFP.
[v] http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SOMALIAEXTN/0,,menuPK:367675~pagePK:141132~piPK:141107~theSitePK:367665,00.html
[vi] According to the MICS, the percentage of children age 12-23 months currently vaccinated against childhood diseases in 2001 was 35% for BCG, 21% for polio at age 3, 14% for DPT at age 3 and 40% for measles. 41% had received no vaccinations.
[vii] One of the most important *underlying* causes of child deaths and illness is malnutrition. In 2006 36% of under-fives were underweight, 42% were stunted 42%. The causes of under-nutrition are varied, complex and interrelated. Some, such as food security and WASH, cannot be addressed by the MOH. The process of strategic planning focussed on those issues that the health services can provide as components of the integrated EPHS. Recognizing that nutrition interventions are a prerequisite to achieving the public health results of the strategic plan, the MOH will continue to support the programming being undertaken by UN, international and national NGOs. The Plan also encompasses improvements to the capacity of MCH clinics that provide treatment for acute and moderate malnourished women and children, deworming and the provision of fortified supplementary food to children under-two and pregnant and lactating women. Somaliland has a Health and Nutrition Sector Strategic Plan that reflects the Somali Nutrition Strategy, 2010 and an Infant and Young Child Feeding Strategy (March 2012). However, capacity to implement these strategies is currently limited. Coverage of critical interventions is low, although precise data is not available. The MOH will continue to support nutrition interventions delivered through health campaigns such as bi-annual Child Health Days. Coverage and quality of all these services can expand and improve as the public health system improves
[viii] "The need for a comprehensive response to HIV/AIDS in NW Somalia: evidence from a sero-prevalence survey" E Abdalla et all, Eastern Mediterranean Journal of Health, Vol 16 #2 2010
[ix] HIV prevalence among women seeking ANC in Hargeisa was 1% 2004 and 2007. ANC surveillance results from 2007 suggest a prevalence of 1.3% with higher prevalence in Berbera (2.7%). Among population sub-groups, prevalence was 1.7% in women aged 15-24 in Puntland, while Berbera recorded prevalence of 4.2% for the same age group, up from 3.0% in 2004. HIV/AIDS is one of the many health issues that is relatively well resourced. The GFATM has invested $70m in AIDS in Somalia since 2004, with a Round 8 grant of $60 million. The government does not satisfy the Fund's requirements to receive funds so the Principal Recipient of the GFATM grants for HIV/AIDS is UNICEF. The main implementing agencies are international and local NGOs, with some public health workers and facilities also contributing to HIV-related services.
[x] Ibid.
[xi] UNDP (2012) Somalia Human Development Report 2012: Empowering Youth for Peace and Development
xii For a detailed review of child health in Somalia, see Child Health in Somalia: A Situation Assessment; 18 February 2011; The Who-Somalia by Wilhelm Zetterquist, M.D., Ph.D

xiiiThe most recent nutrition data is from the FSNAU National Micronutrient and Anthropometric Nutrition Survey, Somalia. 2010

[xiv] UNDP (2012) Somalia Human Development Report 2012: Empowering Youth for Peace and Development

[xv] Lynch C. (2005). Report on Knowledge Attitude and Practices for Malaria in Somalia. UNICEF/Global Fund Partners. Malaria Consortium.

[xvi] The INGOs active in Somaliland are Population Services International, Partners in Health, Save the Children Fund (UK), Merlin, Islamic Relief (UK), Relief International, GRT (mental health), CARE (WATSAN), Coopi (Health & WATSAN), International Committee of the Red Cross/Red Crescent, and Direct Relief International. Local NGOs include The Somali Red Crescent Society and Manhal Charitable Organisation. CBOs include Concern, Biofit, AID, SOMDA, HODMAN that are small very local agencies serving particular communities with technical support, supplies and financing from UNICEF.

[xvii] "A Decade of Aid to the Somali Health Sector, 2000 to 2009". Emmanuelle Capobianco and Veni Naidu. World Bank Working Paper 2011

[xviii] The interventions of the SBNP are management of acute malnutrition, micronutrient supplementation, immunization, deworming, promotion and support of optimal infant and young child feeding, promotion and support for optimal maternal nutrition and care, prevention and management of common illnesses, and monitoring and surveillance. (Only home based fortification is not part of the EPHS).

[xix] The nutrition interventions included in the EPHS are spread across all sub-programmes as follow:

Promotion of maternal nutrition:
- Promotion of appropriate nutrition for pregnant & lactating women, girls & adolescents; MUAC screening and referral
- Antenatal - Iron/folate supplements for 6 months & vit A 10,000iu once; or combined multiple micronutrient supplements, 1 RNI per day
- Postnatal – Iron.folate supplements for 3 months; Vitamin A 200,000iu once during first 6 weeks for mothers or MMN - 1 RNI each day
- Targeted supplementary Feeding Context specific, in liaison with MOH, WFP, UNICEF and agencies for acutely malnourished pregnant and lactating women

Promotion of neonatal nutrition:
- Promotion of immediate and exclusive breast feeding, referral health centres/ hospitals: nutritional care of premature babies and term babies without a mother

Antenatal Care:
- 4 focused antenatal visits including:
- Maternal nutrition counselling during pregnancy, including iron and folate supplements; MUAC screening and referral
- Treatment of disease, and mebendazole for worms
- Treatment of anaemia

Care during delivery: Referral health centres and hospitals: PMTCT through antiretroviral therapy and safer infant feeding practices

Control of diarrhoeal disease, treatment with zinc for 10 – 14 days

Control of measles:
- Standardised case management, including nutritional assessment & support, Vitamin A, prevention and treatment of complications
- Prevention via routine EPI & 6 month campaigns, with vitamin A

Vaccine preventable disease:
- EPI – routine, accelerated and 6 month vaccination campaigns for measles, polio & vitamin A

Promotion of young child nutrition:
- Promotion of exclusive and immediate breast feeding for 6 months
- Promotion of complementary child feeding and diversification of foods
- Nutrition counselling

Nutrition screening:
- Routine nutritional screening with MUAC and look for oedema and referral to health centre/ selective feeding centre ;
- NB No routine wt/ht monitoring or road to health charts; road to health charts replaced by EPI cards.

Nutrition – micronutrient supplements:
- Vitamin A – 6 – 12months 100,000 iu; then 200,000 iu every 6 months until 5 years with 6 month child health campaigns or MMN (see below)
- Iron/folate supplements for anaemia OR multiple micronutrients, 1 RNI each day children aged 6 – 59 months or 2 RNI/ day if fortified foods being used

Care after birth:Routine postnatal care (PNC) for early identification and referral for illness as well as preventive care:
- For the baby: Promotion of healthy behaviours – hygiene, warmth, breastfeeding and immunisation; danger sign recognition (eg fever, rapid breathing, poor feeding, floppy babies, colour change); early identification of illness and referral
- Extra care of low birthweight (LBW) babies including Kangaroo Mother Care (KMC)

Early and exclusive breastfeeding for babies

HIV/AIDS: Referral health centres and hospitals ART with low CD4 counts & nutrition counselling/support for pregnant women

Control of diarrhoeal disease:

Treatment with zinc for 10 – 14 days

Control of measles:

Standardised case management, including nutritional assessment & support, Vitamin A, prevention and treatment of complications

Prevention via routine EPI & 6 month campaigns, with vitamin A

Vaccine preventable disease: EPI – routine, accelerated and 6 month vaccination campaigns for measles, polio & vitamin A

Promotion of young child nutrition:

Promotion of exclusive and immediate breast feeding for 6 months

Promotion of complementary child feeding and diversification of foods

Nutrition counselling

Outpatient therapeutic feeding:

National therapeutic care protocol – with outpatient therapeutic programme for severe acute malnutrition & no complications; monitoring wt/ht and z score and/or MUAC, & oedema; moderate acute malnutrition may be managed with supplementary feeding if resources and programming allow

Inpatient therapeutic feeding

Referral health centres and hospitals – inpatient therapeutic feeding programme/ stabilisation centre - admission for all children with severe acute malnutrition with complications and no appetite following national protocols

Targeted supplementary feeding: Context specific, in liaison with MOH, WFP, UNICEF and agencies formalnourished children aged 6 – 59 months Deworming with 6 monthly campaigns with antihelminthics

Iron and folate supplements at age specific doses

Referral of severe anaemia for blood transfusion

Major wound management: Nutritional support for victims of major trauma: First line care, fluids, nutritional support including therapeutic feeding

Promotion of appropriate foods

Screening & referral for therapeutic care for severely malnourished

Supplementary food for moderately malnourished

Referral Health Centres & Hospitals Only:

Nutritional and medical support :

Promotion of appropriate foods

Therapeutic care for severely malnourished

Supplementary food for moderately malnourished cases

[xx] SMART – Specific, Measurable, Action-oriented, Realistic, and Time-bound.

[xxi]Value for money (VFM) is a term generally used to describe a commitment to ensuring the best results possible are obtained from the money spent and reflects a concern for more transparency and accountability in spending funds, and for obtaining the maximum benefit from the resources available. At its core, value for money is a simple idea: before investing time, resources and energy into an activity or programme, weigh up the costs (what is being put in) and benefits (what is being achieved) of different options and make the case for why the chosen approach is the best use of resources and delivers the most value to the intended beneficiaries. The purpose of VFM is to develop a better understanding (and better articulation) of costs and results to make more informed, evidence-based choices. VFM is a set of assessment practices for appraisal, review or evaluation of systems and functions as well as initiatives; schemes and projects that are time bound but also form part of performance management systems and processes in organizations. As such there are many and necessary links to results-based management, monitoring activity, impact assessment and evaluations.

- Economy refers to the costs of inputs and resources of an intervention (unit costs are typically used as a measure of economy).
- Efficiency refers to how much you get out in relation to what you put in. It's about maximising an output for a given input, or minimising input for an output.
- Effectiveness refers to how far a programme achieves its intended outcomes, using qualitative and quantitative assessments of change.

The assessment of VFM involves examining each of the 3 elements of VFM, identifying the links between them and drawing conclusions based on evidence about how well they perform together. Interestingly, the definitions also refer to an optimal balance, suggesting that it is not the case that the cheapest option always represents better value for money, and pointing to the conversion of inputs-outputs and outputs-outcomes as the subject of real interest in value for money judgements.

[xxii]There are various options for arranging the advertisement, award, financing, coordination and supervision of contractors that the financiers of the Plan and the MOH will have to agree quickly: First, a UN agency could be commissioned by the consensus of the important financiers of the Plan (with the MOH's concurrence) to oversee the award of contracts, a system that operated for the inception phase of the JHNP. Second, the financiers could organize an international competition for a private (non or for-profit) agency to provide this oversight. If the chosen agency

was also tasked with providing Secretariat support to the MOH's Policy and Strategy Unit, it could also develop the capacity of the government to itself manage a contracting process, a valuable skills transfer benefit of such an arrangement that might in the long term lead to government management of contracting. Third, the largest financiers of the plan could agree to award contracts by a series of international competitions for different tasks required to achieve the results of the plan. This approach presents obvious coordination and value for money challenges. It would also place unrealistic absorptive demands on the MOH.

[xxiii] UNCIEF

xxiv The OneHealth Tool developed by the by a group of UN agencies (UNAIDS, UNDP, UNFPA, UNICEF, World Bank and WHO) is a model to be used for supporting the costing, budgeting, financing and national strategies development of the health sector in developing countries with a focus on integrated planning and strengthening health systems. See for further information http://www.futuresinstitute.org/pages/OneHealth.aspx

xxv With the exception of the construction costs for the Somalia TFG MoH central office building construction costs that are presented under the Governance and Leadership Strategic Area

[xxvi] See Costing the Essential Package of Health Services. Report No 9. UNICEF/EU 2009

[xxvii] Numbers of kits distributed to the different level facilities. These numbers are defined based on the assumed consumption of pharmaceuticals and medical supplies that may significantly differ from the actual consumption of these items, data on which is not yet available.